C89

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control

Memorandum

Date August 1982

From Health Services Officer
Division of Health Education

Subject Culture-Bound and Sensory Barriers to Communication With Patients: Strategies and Resources for Health Education

To Colleagues in Health Promotion and Education

The purpose of the attached report, Culture-Bound and Sensory Barriers to Communication With Patients: Strategies and Resources for Health Education, is to provide a resource for health education practitioners that can lead to improved delivery of health education for various cultural groups.

The work was accomplished under CDC Contract No. 200-79-0916 with the Center for Health Promotion of the American Hospital Association, and the resulting report is being duplicated as submitted.

Inquiries related to this report should be directed to this office. Write or call:

Centers for Disease Control
Center for Health Promotion and Education
Division of Health Education
Attn: Roy L. Davis
Atlanta, Georgia 30333
(404) 329-3115
FTS 236-3115

Roy L Davis

Roy L. Davis

NEWARK PUBLIC LIBRARY

NOV 19 1982

U. S. GOVT. PUBS.
DEPOSITORY 376

Attachment

99-1572

HE 20. 7026:

Reports emanating from contract 200-79-0916 are listed below:

- American Hospital Association/Bureau of Health Education Health Education Project - Reimbursement Forum Proceedings, October 25, 1979
- Financing for Health Education Services in the United States - October 1980
- Annual Report: Health Education in Primary Care Facilities - August 9, 1979, to November 8, 1980
- Executive Summary - Financing for Health Education Services in the United States -- Providers, February 1981
- Executive Summary - Financing for Health Education Services in the United States -- Third Party Payers, February 1981
- Statements About the Health Education Roles and Responsibilities of Selected Health Care Providers, September 1981
- Consumer Involvement in the College Health Service, September 1981 (Also: Zapka JG, Dorfman SL. Consumer participation: case study of the college health services setting. Journal of the American College Health Association 1982; 30(4):197-203.)
- Blue Cross/Blue Shield Plan Support for Health Education Services: A Discussion of Issues, May 1982
- Foundation Funding for Health Education 1972-1980, May 1982
- Health Education in Health Departments, May 1982
- Patient Education in Hospital Sponsored Home Health Care Programs, May 1982
- Patient Education in Hospital Sponsored Ambulatory Surgery Programs, May 1982
- Health Education in Federal Health Care Facilities: U.S. Public Health Service; Veterans Administration; U.S. Navy and U.S. Air Force, August 1982
- Health Education in College Health Services, August 1982
- Culture-Bound and Sensory Barriers to Communication With Patients: Strategies and Resources for Health Education, August 1982
- Multi-Institutional Arrangements: A Review of the Literature, August 1982
- Patient Education in Hospital Emergency Departments, August 1982

CULTURE-BOUND AND SENSORY BARRIERS TO COMMUNICATION WITH PATIENTS: STRATEGIES AND RESOURCES FOR HEALTH EDUCATION

AHA/CDC Health Education Project*
Center for Health Promotion
American Hospital Association
May 1982

---

*This project is funded by the U.S. Department of Health and Human Services, Centers for Disease Control (CDC), Center for Health Promotion and Education, Community Program Development Division, Atlanta, GA, under contract number 200-79-0916 with the American Hospital Association, Chicago, IL.

CONTENTS

Acknowledgements v

Preface vii

I. Towards an Understanding of Special Patient Groups: Implications for Treatment and Teaching 1

  Introduction 2
  Communicating with Patients from Cultural Minorities
    American Indians
    Asian and Pacific Americans
    Black Americans
    Hispanic Americans
    Implications for Practice
  Low Literacy as a Barrier to Communication
  Sensory Barriers to Communication:
    Hearing and Sight-Impaired Patients

II. Strategies for Teaching Specific Patient Groups 16

III. Recommendations of Organizations and Individuals Working with Specific Patient Groups 25

IV. Recommendations Applied: An Example of A Patient Interview. . . . 30

V. Resources for Health Education of Special Patient Groups 44

  References
  Transcultural Issues
  American Indians
  Asian and Pacific Americans
  Black Americans
  Low Literacy Skills
  Hearing-Impaired
  Sight-Impaired

  Selected Agencies Providing Health Education and Resource Materials
  Cultural Minorities
  Low Literacy Skills
  Hearing-Impaired
  Sight-Impaired

ACKNOWLEDGEMENTS

The preparation of this resource document was made possible by funds from the Center for Health Promotion and Education, Centers for Disease Control (CDC) (DHHS) under contract #200-79-0916. Roy L. Davis and Beth R. Layson, Community Program Development Division, Center for Health Promotion and Education, CDC, are the project officers for this contract. Project staff from the American Hospital Association's Center for Health Promotion are Elizabeth Lee, project director; Barbara Giloth, project co-director; Mary Longe, project co-director; Gretchen Denny, project staff; and Twyjean Owens, project secretary.

At the time this document was conceived, Gretchen Denny and Elizabeth Lee were responsible for contract activities related to health education for populations that have specific learning needs. A first draft of this paper was written through a collaboration between A. Frances Lindner, M.A., Center for Health Systems Research and Analysis, University of Wisconsin-Madison, and Ms. Denny. Ms. Lindner was the author of the sections that describe cultural characteristics and the resources and agencies for health education; Ms. Denny was responsible for the other sections and for the organization of the first draft. The document in its present form was reorganized and edited by Salvinija G. Kernaghan, who also prepared a new general introduction as well as the introductions to the section on low literacy, hearing impairment, and sight impairment.

The paper was reviewed by Annie R. Collins, Coordinator, Community Development and Intra-governmental Activities; Office of Prevention, Education, and Control; National Heart, Lung, and Blood Institute; Department of Health and Human Services, Rosemond S. Goins, Executive Director, South Dakota United Indian Association, and Effie Poy Yew Chow, Ph.D., President, East West Academy of Healing Arts. They were very helpful in suggesting modifications and changes which were made subsequently.

[illegible]

[illegible]

[illegible]

[illegible]

PREFACE

In August 1979, the Center for Health Promotion of the American Hospital Association (AHA) was awarded a health education contract from the Center for Health Promotion and Education, Centers for Disease Control, DHHS. Two major goals for the first year of the project were to describe the patient and community health education activities that were being implemented in a variety of ambulatory health care settings and to collect more specific information about the issues that are crucial to the growth of effective health education programs. During the second contract year, particular issues were identified for study from discussions with practitioners in the various health care settings; among these issues was the need for assistance to effectively educate specific cultural groups. The two major barriers to effective education, according to the practitioners that were interviewed, are (1) the difficulty in communicating with non-English speaking clients and (2) the frequent mismatch between modern medical practice and these clients' traditional healing practices and other beliefs.

Purpose of This Document

With these barriers in mind, the broad purpose of the activities that have resulted in this document has been to provide a resource for health education practitioners that can lead to improved delivery of health education for various cultural groups. In addition, consideration of two other special groups of patients has also been included because they often experience some of the same impediments to effective health care and appropriate health education. The first group is composed of patients with low literacy skills, while the second includes patients who are hearing- or sight-impaired or both. This document attempts to meet its goal of assisting health educators working with these special groups of patients by providing several kinds of information:

- a basic description of the characteristics of each group as these may influence acceptance of and compliance with medical treatment and related health education
- general recommendations for health care providers to guide them in communicating with these special patient groups and in establishing acceptable courses of treatment
- some suggestions for health education coordinators to identify and implement health education activities that meet the needs of these groups of patients.

The information provided does not attempt to discuss all the issues that are related to the medical treatment and health education of these special groups of patients. Rather it is an initial effort to guide practitioners toward better understanding and meeting the needs of these groups.

Intended Audience

Because the intended audience for this project includes both health care clinicians and health education coordinators, the particular needs of both have been considered in compiling the information that is included in this document. Health care clinicians may already be aware that some adjustment in their normal modes of communicating with patients must be made in order to relate effectively with the special groups of patients discussed in this document. However, the scope of these professionals' responsibilities does not often permit them to be fully informed about the psychosocial characteristics of special patient groups nor about the impact these traits may have on health care. A health care professional who belongs to a minority cultural group and serves patients from the same group can often help eliminate problems of communicating with such patients. Therefore staffing that considers the similarities of professionals' and patients' cultural backgrounds has much to recommend it. However, the fact remains that very few minority health care providers or health education coordinators are available to serve their own cultural group. This is even more the case with the hearing- and/or sight-impaired and especially with those who demonstrate low literacy skills.

Therefore, a document such as this can provide some basic guidelines for those practitioners who work with patients with whom communication is limited because of cultural or physical differences. The recommendations of several organizations that have studied the special health care and health education needs of minority groups are included in Section III of this document. These recommendations may assist practitioners to foster some organizational/community-wide activities that can generate awareness in and attention to the specific needs of minority patients.

Methodology and Organization

This document was developed through analysis of reports, proceedings, and articles pertaining to the health education of the special patient groups. In addition, providers in health care settings, cultural resource centers, and individuals from the four cultural groups were interviewed by telephone or contacted by mail. National agencies and organizations that provide clearinghouse data bases on health education materials were contacted, and Medline searches were conducted in health related areas. This paper documents the results of that information search.

Section I of this document provides a brief description of the characteristics of some special patient groups whose level of communication skills in English may make understanding of and compliance with health care instructions difficult. These descriptions are arranged as follows:

- Minority cultural groups
  - o American Indians
  - o Asian and Pacific Americans
  - o Black Americans
  - o Hispanic Americans
- Patients with low literacy skills
- Hearing-impaired patients
- Sight-impaired patients

Section II is a review of educational principles that should be applied in implementing strategies for teaching audiences with special needs.
Section III outlines the recommendations of organizations and individuals who have experience in working with the special patient groups that are discussed in this document.

Section IV presents an interview between a health care practitioner and a patient of Hispanic background. Their exchange provides some insight into what a cross-cultural interaction might be like and how a practitioner is able to incorporate elements from another culture into the patient care process.

The final section is provided for staff members who wish to read other resources on the needs of a specific group. The section presents a bibliography on health education for patients with hearing and sight impairments; it provides annotated and nonannotated bibliographic sources pertinent to each of the four cultural groups as well as to patients with low literacy skills; it also lists relevant agencies and their health education resources. Sources were chosen for annotation that were more practice oriented and had information directly applicable to each group. References considered supplemental reading to the annotated materials are older classics, more theoretical work, or were judged to be less relevant to health care delivery. The bibliographies for the cultural minorities focus on the following categories as they relate to health care:

- o folk medical beliefs
- o how different groups perceive health, illness, and health care delivery systems
- o religious beliefs
- o communication--language differences

Many of the articles were chosen because they provide recommendations for provider practice. Some of these recommendations are listed in Section I.

It is hoped that this compilation of information and resources will stimulate practitioners to further explore and learn about the individual clients with whom they work, familiarize them with strategies for working with specific groups, and enable them to locate resources for the development of their programs.

SECTION I

TOWARD AN UNDERSTANDING OF SPECIAL PATIENT GROUPS: IMPLICATIONS FOR TREATMENT AND TEACHING

INTRODUCTION

An essential component of effective health care is the nature of communication between the client and practitioner. Successful treatment depends heavily upon the ability of both parties to communicate so that appropriate decisions regarding health care are made. Information about the client's behavior patterns is essential to determine the course of treatment or of patient education. Differences in culture, language, level of literacy, as well as physical impairment (for example, hearing and sight) will influence communication and behavior patterns. For the practitioner, an ability to understand and communicate effectively within a broad range of circumstances such as those mentioned is necessary when working with clients from special patient groups.

Cultural differences represent a significant factor in communication between client and practitioner. For some clients, customs and belief systems incorporate health care activities that are different from those practiced in the dominant American health care system. A client's concept of health and illness and the method of treatment can have a major influence on health care. This document will discuss some of these differences and provide resources for further reading.

Another factor that can influence communication between client and practitioner is that of low literacy. Lack of education and/or language differences will have a direct bearing on a patient's ability to understand and comply with health care. The document will also discuss the barrier of low literacy and provide suggestions and techniques for improving communications with clients having a low level of literacy or for those who are illiterate.

A third part of this document discusses communication with clients having two types of sensory impairments -- those of hearing and sight. Attention is given to the need for practitioners to be sensitive to modes of communication that rely heavily on the client's remaining sensory resources, such as touch for the sight impaired. For the hearing impaired, sign language is discussed as an effective device for improving communication.

COMMUNICATING WITH PATIENTS FROM CULTURAL MINORITIES

Individuals who are not members of the dominant American culture often make unique demands on health care providers and health education coordinators. Because communication and language are elemental expressions of culture, barriers to communication often arise when client and clinician have different modes of behavior, language, and/or beliefs systems. Practitioners must therefore attempt to understand these differences and respond appropriately. For example, sex roles within various family or social structures may differ from those in the dominant American culture and may strongly influence decision-making regarding health care, especially for female family members. In this regard as well as on other issues, the clinician and the educator must be aware of his or her own values as they relate to the client's values, because such differences in opinion and value orientation can interfere with health care delivery. Sensitivity to different beliefs and practices can help alleviate some of the internal conflict experienced by the client in a health care setting as well as minimize alienation of client and family.

This portion of Section I presents some of the primary sociocultural issues relevant to the health care of four cultural minorities in the United States. Some of these issues may apply to more than one group. Certainly a client's ability to comprehend spoken and written communication should be identified in every circumstance. In addition, various sensory changes or impairments that effect normal communication channels must be evaluated and considered, no matter what a client's cultural background. Finally, some health-related and culture-bound concepts may be cross-cultural. For example, the hot-cold theory of health and illness representative of traditional health care practice appears in Asian and Pacific cultures as well as Hispanic cultures. However, each culture has its unique method of defining and categorizing elements of folk medicine found within that particular system. Variations within a similar pattern of practice will necessarily occur. It is therefore important to examine the information specific to each group.

AMERICAN INDIANS

Broad differences exist among the many subcultures of the American Indian. It is therefore extremely important for the clinician and the educator to be aware of the cultural characteristics unique to the specific group and individual for whom they are designing treatment regimens or education programs. Presented here are some notes from the literature on American Indian culture and health care. To help further identify these differences, health professionals may seek information about groups with whom they are working by consulting their area's Indian Community Tribal Council or Indian health professionals.

As an example of the kinds of information that are available from such sources, the South Dakota United Indian Association provides information on cultural differences and has written a sensitivity packet for non-Indian clinicians. In one of its publications, the association describes the different lifestyles of traditional (reservation), contemporary (urban and reservation), and cosmopolitan American Indians.

Traditional Indians maintain their culture and traditions within their Indian communities through medicine men and religious practices; their language and cultural practices are totally integrated into their daily activities. In comparison, the contemporary or bicultural Indian is usually found in urban centers and often maintains a balance between the two cultures by living in both reservation and urban environments and internalizing both cultures. Some individuals are successful in becoming bicultural, while others are unable to cope with the "double standard" and exhibit mental and emotional instabilities, alcoholism, and drug abuse. Cosmopolitan Indians are integrated into Anglo culture, often intermarry with Anglos, and adopt Anglo identities. Currently, however, a growing number of cosmopolitan Indians are returning to their tribal identity.

The persistence of traditional healing practices is an important factor in Indian health care. In his article on the Zuni Tribe of New Mexico, Camazine (1980) outlines some important observations and recommendations pertaining to the coexistence of traditional and Western health care systems. Other sources document the need to collaborate whenever possible with traditional health care practitioners.

Some Cultural Characteristics. Although the definition of immediate family members will differ among tribes, the Indian family structure is characterized by an extended family unit with strong kinship ties. Both matriarchal and patriarchal systems function in certain tribes with ownership passed on through the mother, but also communal, i.e., shared with others. Interdependency between individuals and responsibility to the tribe are highly valued, as are respect for an individual's rights and noninterference in another's personal life unless requested. Respect for elders is also a primary element of Indian culture.

A number of cultural characteristics of American Indians may have a marked impact on the success of communication with and treatment of patients from this cultural group. For example, closeness to nature is characteristic of Indian cultures, and death is accepted as a part of the natural cycle. The concept of time is based on a continuum that focuses on the present rather than being future oriented. There is a strong belief that many events cannot be altered by humans.

Religious Beliefs and Tribal Healing Practices. Religion helps to maintain stability and gives a sense of cohesion to an individual's life; it is not separated from health care as it is in most Western cultures. The religion is based on belief in the almighty Mother Earth. "Bad" happenings are viewed as punishment, and "good" happenings viewed as reward. The religion is incorporated into daily activities and maintained by teaching and example. Religious and healing practices are interrelated in rituals, and illness is interpreted as a sign of disharmony with nature. American Indians have a holistic concept of health care. Signs, symptoms, as well as causes are treated. Illness is considered to be caused by either natural or supernatural influences. Tribal rituals often involve the use of foods sacred to the particular tribe; for example, corn is considered curative by some groups. Cedar also may be important in religious healing rituals or in medicine bags.

Death rituals and taboos vary between groups, and attitudes vary about touching the body. Although tribal healing practices differ between groups they usually include:

- purification of the patient and the medicine man
- the Navajo practice of a Sign (ritual, chants, and sand painting lasting for various lengths of time)
- smoking religious tobacco
- gentle massage
- small sacrifices
- prayers

Other traditional approaches to health care are herbal remedies and bone setters. Some Indian groups take traditional medications, such as herbal teas, in large doses. The implications of this practice for prescribing medication by non-Indian medical staff is that clinicians and pharmacologists must strongly emphasize the need to take Western medications according to their prescribed doses.

Communication. Display of emotion is encouraged in some tribes but discouraged by others. Intense eye contact often is considered disrespectful; clinicians have often misinterpreted this as the client being inattentative or disinterested. Handshakes are an important symbolic gesture, although in some groups a vigorous handshake is sometimes viewed as a sign of aggressiveness.

Many American Indians do not speak English; among these are the many rural elderly who live on reservations. When an interpreter is needed in the clinical situation, a bilingual family member may be the most helpful person. Because public education is conducted primarily in English, children or grandchildren of elderly American Indians in rural areas often are bilingual. However, misinterpretation can occur even with an interpreter. Some English words and concepts do not exist in Indian languages or are not easily translatable; the reverse is also true of some Indian words and concepts. Special care should be given to clearly identify the client's symptoms and to explain the illness. This requires more time and patience for both parties. If possible, clinicians should meet with the interpreter before seeing the client in order to more fully discuss ways to best communicate medical terms and treatment.

ASIAN AND PACIFIC AMERICANS

Among Asian and Pacific Americans are included those cultural groups that have migrated from China, Japan, Korea, Southeast Asia, as well as Hawaii, Philippines, Samoa, and Guam. In her article on Asian-American patient care, Chang (1981) identifies four categories of Asian Americans that represent varying degrees of assimilation into Anglo culture and are identified by specific behavioral characteristics:*

- o traditional Asians adopt traditional Asian values and behavior, which include obedience to parents, respect for authority, self-control of strong feelings, humility, praise of others, and blame of self for failure; health- and illness-related practices manifest a balancing of Asian and Western traditions.

---

*Adapted and reprinted with permission from George Henderson and Martha Primeaux, Transcultural Health Care, p. 275. Copyright 1981 by Addison-Wesley Publishing Co., Inc.

- Asian Americans practice a balance of traditional and Western values, which include a degree of respect for parents and authority, individual self-assertiveness, lack of self-effacement, and some expression of feelings. Health- and illness-related practices are predominantly Western, but maintain some Asian characteristics.
- Americanized Asians have fully adopted Western values and behavior, which include development of individuality, openness of expression, assertiveness, independence, and self-confidence. Health- and illness-related practices approach those of middle-class Americans.

New immigrants generally would fall into the first category. However, it is important to stress that these characteristics vary in degree according to individuals and groups, and only some of these may be present in any one culture.

Family relationships. Family structure varies in Asian cultures. It is useful for practitioners to know whether a client is from an extended or nuclear structure in order to better identify resources available to the client in terms of family involvement in the health care/treatment process. Authority of the household can rest with either the father, the mother, or both. This has implications for decision-making in terms of health care, and the clinician should consult with the appropriate authority of the household when major decisions are to be made. For example, Burmese authority rests with the father-mother pair, whereas in Guamanian families decisions generally are made by the father. (Yip, 1980) In most of the cultures, a husband often will act as spokesperson for his wife.

Medical Beliefs and Practices. Asian and Pacific cultures are characterized by the Yin-Yang philosophy. Yin and Yang represent opposites of each other, but are complementary in nature. Foods as well as a hot-cold classification of diseases are generally categorized according to the balance of Yin and Yang, although specific classification of foods and/or diseases varies according to the particular culture. Yin diseases fall into a cold category, while Yang diseases are considered hot. For example, Chang (1981) cites cancer as a representative of a Yin, cold disease, whereas an ear infection is thought of as a hot disease and Yang. Yin illnesses would be treated by Yang foods, and Yang illnesses would be treated by Yin foods. A detailed explanation of these medical practices is found in Transcultural Health Care (1981).

BLACK AMERICANS

While cultural differences in beliefs about health and illness often create communication barriers between clients and clinicians, social class and racial differences present even further obstacles to health education when a lack of understanding of a client's position influences the behavior of the clinician.

The sociohistorical relationship between Black and White Americans has left broad gaps in levels of trust and communication. Cultural differences, access to services, poverty, and level of education are only some of the barriers to effective medical treatment and health education. Sensitivity to some of these issues depends in part on understanding some basic sociocultural characteristics that influence health care for Black Americans.

For example, adverse environmental and economic factors can increase stress and lead to poor health. Many Black Americans live in conditions of poverty that prevent their access to and utilization of orthodox health care. It is important to recognize that many of these factors are caused by barriers to socioeconomic mobility. An awareness of the socioeconomic issues that affect minorities can help the clinician be more sensitive to the needs of the client in terms of both physical and emotional support. In addition, health care providers must be informed about the special physical characteristics of Black Americans as well as about the common diseases more prevalent in the black population. In her article entitled "Nursing Interventions in Black Patient Care," Bloch (1976) outlines some characteristics that can help clinicians be sensitive to and recognize physiological changes that may indicate a health problem.

Family Relationships. Black American culture is influenced by African social traditions. The extended family and interdependent kinship ties are characteristic of both rural and urban communities. Health care is often viewed as a family responsibility, not just that of the individual and clinician. The clinician therefore can often solicit other family members as aids in caring for an ill Black American. Interdependence and interchangeability of roles within a family setting is often present in Black American families. Therefore, authority within the family may rest with either a male or a female as head of the household.

Religious Beliefs. Because religion is an important aspect in Black American culture, members of the clergy are an integral part of the Black community. In many communities, they are trusted by and familiar with family members to such a degree that they can be helpful to clinicians as liaisons between a family and a health practitioner or institution.

Because religion is such an integral part of the culture, illness may be viewed as punishment by God for sins. Therefore, the clinician should be alerted that feelings of guilt may be influential in the client's perception of an illness. In such instances, the clinician may want to consult with or suggest that the client meet with a member of the clergy in addition to medical staff. In some instances, religious beliefs and practices have been perceived as mental illness; for example, a client may report hearing or talking with God. This, however, could also be an expression of a client's religious belief. The clinician should understand that expression of such beliefs and practices is not necessarily symptomatic of mental illness and should examine nonreligious factors when determining causes or symptoms of illness (Snow, 1980:51).

Much of Black folk medicine comprises elements from both Christian and traditional African tribal religions. In addition, voodoo, a component of Black folk medical practices, is influenced by Haitian beliefs. Traditional healing practices include mystic (supernatural) phenomena, psychological support, and herbal remedies. Herbal practices are found primarily in rural areas. In urban centers, religious and medical folk practitioners provide psychological and spiritual support.

In urban areas, Black spiritual advisors and folk practitioners are often called on to relieve anxieties and fears of living in the hostile and dangerous environment of the city. In this way, they perform the role of psychotherapist. Charms and other objects are frequently worn for protection or as a form of preventive medicine. For example, a small bag containing herbs or other elements may be worn to ward off evil spirits.

Causes of illness may be attributed to witchcraft. Loudel Snow (1980) divides symptoms of witchcraft illness into two categories, namely gastrointestinal and behavioral. Symptoms that do not respond to treatment may be perceived by the client as a result of a "hex." Abrupt changes in behavioral patterns also may be attributed to this cause.

Clients who express belief in witchcraft should be taken seriously. It is helpful for the clinician to find out why the patient feels she or he has been a victim of witchcraft, because this information can help the clinician make a determination for diagnosis or treatment of an illness.

In many instances, a breakdown in social relationships is influential in the perceived causes of symptoms due to witchcraft. (Snow, 1980) Black clients may be reluctant to talk about witchcraft or folk practices they have undertaken. However, in order to provide appropriate treatment, it is important for the health care provider to ask specifically which healing practices have been used.

Communication. The dialect of Black Americans is an integral part of Black American culture. It has been influenced by English and African languages as well as by geographical location and social factors. The health terminology of the clinician can be confusing or misunderstood by a client even though she or he speaks English. It is important for clinicians to speak clearly and to explain terminology when discussing matters concerning medical treatment. A familiarity with lay Black medical terminology and its differences from scientific terminology can help avoid misunderstandings in communication and misinterpretation of symptoms the client describes. It also is important for the clinician not to try to adopt Black English unnaturally, because this may be viewed by a Black client as both patronizing and inappropriate.

HISPANIC AMERICANS

Hispanics constitute the second largest ethnic minority group in the United States. Generally, the following groups are referred to as Hispanics: Cubans, Mexican Americans or Chicanos, Mexican immigrants, Puerto Ricans, and South Americans. It must be emphasized that Hispanic cultures are diverse:

important cultural differences exist between these groups. Many of these differences are a result of extremely varied historical, social, economic, and political experiences.

Family Relationships. Identification with and unity of the family are highly valued and constitute the nucleus of Hispanic culture. Close kinship relationships characterize the family structure, which is a primary source of emotional, physical, and psychological support. Individual needs are considered secondary to those of the family. Family structure may be either extended or nuclear. (Martinez, 1978) The nuclear family comprises immediate members, i.e., father, mother, and children. The extended family incorporates other relatives, such as the grandparents, aunts, uncles, and cousins.

Generally, authority in the Hispanic family rests with the eldest male. Most major decisions, therefore, will be made by either the father or the husband. It is important that clinicians involve the head of the family in major health decisions such as hospitalization of family members. In terms of health care, responsibility for care of an ill family member will rest with other family members. Usually, clients will have consulted with various family members before seeking outside care.

The Importance of Privacy. Modesty is highly valued. Health care professionals should take care to minimize situations in which an Hispanic client may feel compromised. In particular, communication between client and clinician should demonstrate respect for the client's needs in this area. As examples of situations in which regard for modesty is important, Health Education and the Mexican American (University of Texas, 1977) suggests that the mother be present for examinations of a female child. However, it may be embarrassing for the mother to observe the genital examination of a male child. Sensitivity to these cultural norms will help avoid embarrassment for parents and children. Interruptions of privacy during the consultation should always be avoided, especially during examinations.

Religious attitudes and beliefs. Religious and fatalistic attitudes may influence a client's approach to an illness and its treatment. For example, the client may believe that illness is a result of punishment from God and that medical care cannot change the course or outcome of an illness. This has implications for the methods used for treatment as well as appropriate ways of communicating with the patient about regimens. In terms of treatment, it is important to discuss what the client's reservations are and to identify what steps the client might be willing to take. Second, it may be useful to refer the client to a respected member of her or his religion, e.g., a priest, to discuss how management of a medical problem fits within the religion's framework.

Folk medical beliefs, folk medical practitioners, and rituals comprise traditional Hispanic health practices. The hot-cold theory of disease organizes illness and cures into categories identified as either hot or cold. However, hot-cold categories vary among Hispanic groups. For example, Puerto Ricans have a "warm" classification in addition to hot and cold. Foods and herbs are also classified in these categories as well as illnesses. Unless the prescribed regimen fits the client's assessment of what treatment is appropriate, adherence to a regimen is likely to be minimal. Again, therefore, it is important for a clinician to identify the client's hypotheses about health problems and their treatment.

The espiritista (spiritualist) and/or curandera or curandero are some of the folk practitioners seen when treatment is needed in many traditional Hispanic communities. They may be consulted before an orthodox health practitioner. The clinician should ask the client whether he has consulted such a practitioner to determine what ethnopharmacological medications have been used. Robert Trotter outlines some common folk illnesses and remedies in his article, "Remedios Caseros: Mexican American Home Remedies and Community Health Problems."

One frequent reason for Hispanic clients' preference for traditional folk practitioners is distrust of orthodox medicine and staff. Welch, Comer, and Steinman (1973) found that distrust usually is based on past experiences with medical staff rather than on culturally-related factors. Other factors in underutilization of orthodox medical care are inadequate income, low level of education, and age.

Communication. Communicating in a language that is uncomfortable for the client can change the client's expression of symptoms or may be misinterpreted. When language differences between Spanish-speaking clients and non-Spanish speaking clinicians exist, it is recommended that a bilingual interpreter be used. This may be a family member, a friend of the client, or a trusted individual within the community who is able to act as liaison.

IMPLICATIONS FOR PRACTICE

The foregoing is a simplified version of the complex sociocultural factors that influence the dynamics of health care and health education for cultural minorities. Nevertheless, it is sufficient for emphasizing the need for practitioners to be aware of and respond to these factors. The material further suggests some specific actions, which can be summarized as follows:

- Regard the client's family--and sometimes the client's immediate community--as his or her support system. When feasible, allow family members sufficient time to consult one another before a decision is made regarding a client's health care. Incorporate family cultural preferences (for certain foods, for example) into the client's treatment regimen.

- Recognize the importance of religious and/or folk medical practices and beliefs to the client's treatment. Ask the client whether a folk practitioner has been consulted and what treatment that practitioner recommended; attempt to establish compatibility between the traditional course of treatment and the course that is prescribed by modern medical practice. When possible, establish communication with cultural practitioners for information and/or assistance. (For an example of such collaboration, see Section IV.)

- When communicating with a client, use all possible avenues to both convey and understand messages:
    - be sensitive to nonverbal communication
    - ask questions so that they may be answered with a phrase, rather than with "yes" or "no"
    - listen to answers attentively
    - explain all information--the diagnosis, the treatment, the prognosis -- carefully and completely, but with the simplest terminology possible, and ensure that the client understands by having him or her explain it in return (see recommendations for low literacy later in this section)
    - use the client's family members or friends as interpreters
    - contact local ethnic/community organizations that may be able to provide experienced translators
    - when appropriate, consult with the client's religious/community leaders to gain more information about the client's needs and resources or to gain support for a course of treatment the client finds culturally unacceptable
    - when prescribing medication, explain why, when, and in what amounts the medication must be taken and what its effects should be; use prescription labels written in the client's language and/or graphic symbols to convey instructions
    - use picture/graphic or audiovisual materials that have been translated into the client's language (some sources for such materials are listed in Section V)

In general, the foregoing information stresses that practitioners who provide frequent service to a cultural minority should attempt to include bilingual/bicultural professionals and paraprofessionals into the health care setting's staff or to use them as liaisons with the community. Their presence will enhance the entire staff's awareness of the special needs of the community being served and will help to establish a collaborative relationship between the practitioners of Western medicine and those of traditional folk healing.

LOW LITERACY AS A BARRIER TO COMMUNICATION

The literacy level of a patient/client should be ascertained whenever possible before further attempts are made to establish effective communication about the patient's health. When this is not possible, it is often correct to assume that the person reads and comprehends at one or two grade levels below his or her highest school grade completed. However, one study of patients found that average word recognition skill was four to five grades lower than the level of schooling declared by patients. In comparison, the standard surgical consent form used by most hospitals demands the reading ability of a senior in college. Other written materials, such as hospital policies, drug-related instructions, and patient education pamphlets, often demand at least an eighth grade reading level; oral instructions are frequently presented at a tenth grade level or higher. (Chatham and Knapp, 1982)

Patients who demonstrate difficulty understanding--and therefore complying with or learning from these instructions--are often considered uncooperative. However, the notion that literacy depends on motivation could be a misconception. A reading problem may be due simply to insufficient education for the reading and comprehension being demanded. Doak and Doak (1980) found that even the most cooperative patients became frustrated and anxious when their reading and listening limits were reached. The only opportunity that patients with low literacy skill may have for accurate health information may be in the health care setting. (Doak, 1980) Therefore, practitioners should attend to their information needs, without, however, attempting to teach reading.

IMPLICATIONS FOR PRACTICE

A major task in reaching clients with low literacy is to simplify the language used in health related materials. Chatham and Knapp (1982) suggest the following techniques:

- speak and write in short sentences, conveying no more than one concept per sentence
- use short words; one or two syllable words are best
- speak or write words that will mean something to the patient rather than words that are technical or unusual
- speak or write in a conversational, active voice (e.g., "you should take two tablets," not "two tablets should be taken," etc.)

Others suggest the use of graphic symbols to ensure that patients understand instructions--for example, those on medication/prescription containers. (Meisel and Keily, 1981) Other similar recommendations that appear in the resources listed in Section V should help guide practitioners to communicate in a manner that is comprehensible to non-English speaking, semi-literate, and illiterate clients.

PHYSICAL BARRIERS TO COMMUNICATION: HEARING- AND SIGHT-IMPAIRED PATIENTS

Assessment of a patient's hearing and visual acuity is as important to establishing effective modes of communication as is the identification of a client's culture-bound behavior patterns. Blindness and deafness are each the extreme of a continuum of sensory disability along which some degree of acuity may remain to assist communication. It is also helpful to discover when the sensory impairment occurred in a patient's life, because its onset will have had great impact on the patient's opportunities for normal language learning--and therefore on his or her level of literacy. For example, a patient who was born with a hearing disorder will not have had the same opportunity to hear and read normal English--including medical terms and other health related-information--as would an elderly patient whose hearing loss has been related to the aging process. A middle-aged diabetic whose related loss of sight is recent may exhibit fluency that a person of the same age who has been blind from birth will not command.

These differing levels of acuity not only effect a patient's communication with a clinician but also influence the ability to benefit from health education materials and services. For example, in media preparation for the elderly, it should be noted that older people may see some colors more easily than others: yellow, orange, and red are more easily perceived than violet, blue, and green. This is due to the yellowing of the lens with age. It also can be difficult to distinguish between levels of brightness. A blue and green poster with subtle gradations of color to illustrate certain points may be ineffective for an elderly audience.

IMPLICATIONS FOR PRACTICE

Perhaps the most important recommendation that a clinician can apply in dealing with the hearing- and/or sight-impaired patient is to be constantly aware of the need to use only those modes of communication that the patient is able to use:

o For the sight-impaired patient, this means a greater--or total--dependance on oral communication. It also means that demonstration--for the purpose of explaining the course of pain, for example, or teaching insulin injection techniques--must depend on the sense of touch rather than on visual observation. It also often means that the patient must be physically guided through the unfamiliar environment of the health care setting, and that anyone who is working with the patient should constantly describe what is happening or is about to happen; for example, an injection should not be administered without the patient's being told first what he is about to feel. Finally, it should not be assumed that a person who is blind is automatically capable of reading health-related instructions in Braille. As with the other special patient groups that have already been described, the clinician should identify the resources the patient has at his disposal and the other persons that make up the patient's support system and use these whenever it is appropriate and beneficial.

o For the hearing-impaired person, the clinician must identify the mode of communication that is most comfortable for the patient and then use that mode. Lip- or speech-reading is rarely effective for the totally deaf patient, although it may assist the patient who is partially deaf. Writing messages is also of limited value to the deaf person whose disability has impeded acquiring fluency in reading. Probably most effective is the use of an interpreter by sign-language--either someone who accompanies the patient or an interpreter from the health care facility's staff. The encounter between the practitioner and the patient--and the interpreter--should be controlled in such a way that the patient can see both the other parties, that no light is shining into the patient's eyes, and that the patient is provided with frequent visual reassurances and demonstrations.

Health education materials that are designed for patients with either hearing or sight impairment should be used whenever possible. Some sources for such materials are listed in Section V, along with the names of agencies and organizations that can help health care practitioners to enhance their knowledge about and abilities to care for these special patients.

* * *

Section II

STRATEGIES FOR TEACHING SPECIAL PATIENT GROUPS

A practitioner who intends to provide effective health education to members of a special group must possess a variety of skills and information. These include not only an awareness of the characteristics and needs of the population as has already been discussed, but also teaching/learning skills and knowledge of available resources for education. This section reviews some elementary principles on which appropriate communication and teaching skills may be developed and health education strategies planned for specific populations. The areas that must be considered are assessment, content, faculty, and methodology.

ASSESSMENT

Not all individuals who are members of a particular group share the same characteristics. Therefore, individual assessment is very important. Though practitioners may feel that assessment is routinely done, it is important to note that members of special groups have indicated that they do not feel their special needs are known or met. Because assessment has already been discussed in the context of the special groups in the previous section, suffice it to say here that the results of an accurate assessment of client needs must form the basis of all program planning and implementation.

CONTENT

In determining the content of the program to be developed, self-determination of the target population should guide the planning. Members of the group to be reached should be included in the planning phase of the program and/or should provide comments on its proposed contents. In this way, a better understanding of the needs and capabilities of the group can be achieved. As the program is implemented, clients can provide formative and summative evaluative feedback (that is, during the program and after its completion), and these evaluatious should be used to guide future program modifications.

FACULTY

In selecting faculty for specific cultural minorities, greater success of the program is probable by the choice of culturally accepted and recognized leaders. There are a number of reasons for this. The inclusion of peers as faculty greatly enhances the credibility of the program by providing role models with whom the clients can identify. For optimal communication, knowledge of the regional differences between language dialects is important. Standard college Spanish will be different from the colloquial speech or dialect of the various groups. For example, the Spanish spoken by Puerto Ricans in New York differs from that spoken by Mexican Americans in Texas. Attention to this factor will help ensure higher levels of communication. When it is impossible to provide faculty from the specific group, the use of bilingual/bicultural interpreters is helpful.

In the event that the group to be taught is hearing impaired, their preferred mode of communication should be identified, and it is likely that someone versed in American Sign Language will need to present or interpret instruction materials.

CHARACTERISTICS OF PRACTITIONERS

Practitioners who provide health education to specific populations can be more successful if they possess or attempt to develop certain skills and attitudes. A review of the literature suggests that the following traits are valuable:

1. Practitioners must develop familiarity with, interest in, and sensitivity to the psychosocial and cultural characteristics of the population they serve and the manner in which these influence health behavior. Lack of attention to these factors can alienate the client and lead to noncompliance. For example, alienation of clients was reported in a 1974 study of low-income Blacks and Hispanics who described problems in the following areas:

    a. insensitivity of service providers to cultural and ethnic differences

    b. disinterest in patients and their culture-bound responses to illness

    c. lack of understanding and appreciation of cultural impacts on therapeutic processes
    d. lack of interest among practitioners in reaching out to patients (Jennings, 1974)

    In contrast, a homophilous relationship of teacher and learner enhances the effectiveness of the teaching-learning effort. (Alcalay, 1980) When health education practitioner and client are homophilous, that is, similar in such attributes as education, social status, and beliefs, the sort of dialogue and discussion that uses the cultural and linguistic patterns of the learner group may be possible. This has been an effective format for education of culturally distinct groups. (Friere, 1968) When the instructor is culturally or otherwise significantly different from the clients, it may be useful to ask the client group to identify these differences and discuss how they can be used as a resource in helping the clients achieve a higher level of adherence. Allowing the clients to contribute to the information that is being processed helps to make the information relevant to them and alerts the instructor to the kinds of difficulties clients may have in understanding the information or incorporating it into their lifestyles.

2. Good communication skills required to work with various groups involve language and interpersonal skills. The practitioner must be able to speak the language of the client or use an effective interpreter in order to explain and listen. The practitioner must also become familiar with colloquial speech patterns and be comfortable with clients' language (vocabulary and lay medical

terminology). Beyond mastery of the client's language, the affect and interpersonal skills of the practitioner are also important. In order to be effective as a change agent, the practitioner must be able to use the tools of language to actively listen to the client's needs, impart information, and facilitate understanding and motivation.

If practitioners who have a good command of the language of a client population cannot be added to the staff, innovative thinking must be applied to solve the problem, especially if lack of resources make the ideal situation impossible. For example, one hospital, noting the need for patient education in a variety of languages, surveyed its entire staff and now has a catalog of employees who are fluent in languages other than English and who act as interpreters as the need arises.

3. Knowledge of other--especially of successful--programs is essential to the practitioner whose work responsibilities leave little time to innovate and no desire to "reinvent the wheel." Bolton, a practitioner, states that "successful programs must be communicated to others so that a broad base of health care workers who are capable of addressing the needs of a culturally diverse society is developed." (Bolton, 1981) Therefore, some mechanism for sharing innovations is desirable. Within an institution, inservice departments could disseminate information as well as teach communication skills. Bolton suggest that those departments "should provide ongoing educational opportunities that address the cultural and psychosocial aspects of health care." Furthermore, the literature that describes innovative health education programs for the patient groups considered in this document is sparse and does not reflect the level of activity in the field. Practitioners who are working to meet the educational needs of these groups should make the effort to document their experiences and share their programs through the literature.

METHODOLOGY

The planning of a methodology for reaching a specific population must consider a number of factors. The first is the evaluation of assessment data. Second is the incorporation of adult learning principles. Finally, the methodology should be planned using multiple approaches. These concepts are briefly described below.

1. Assessment data

An examination of the social, cultural, economic, and health factors of the audience will help to identify which factors could influence the methodology. As has already been suggested in Section I, some significant factors to look for include literacy, sociocultural background, language use, sensory changes (e.g., loss of visual acuity that would affect perception of subtle colors, forms), and other physical limitations. Family relationships and support systems should be defined if a strategy to promote behavior change is being planned.

2. Learning principles

A review of key principles for effective learning follows:

a. The learner should be active rather than passive, because retention of information is enhanced by participation. The learner will have greater competence in the new skill if (s)he has been given the opportunity to ask questions, apply information, and practice the new skill with feedback from the instructor.

b. The learner should be able to examine and understand the thinking that preceded the teaching activities. A client's adherence to the principles advocated in a health education program depends largely upon having a sense of the usefulness of the information. Congruity of theory and practice is essential. Adult learners have a need for direct application of the new concepts to their daily activities (Knowles, 1978).

c. There should be a variety of educational options provided for the learner. Applications of this principles will be considered below, but it is worthy to note that "research has shown that the lecture is more useful for conveying cognitive information and is less productive for teaching problem solving. Small-group discussions promote more problem solving but are less appropriate for skills development than are structured practice sessions." (Foley and Smilansky, 1980) However, many factors often combine to make the choice of method somewhat arbitrary. Even within a homogeneous group, there are individual differences that influence each person's learning preferences.

d. The learner should be able to see or examine the successful behavior in order to know the criteria for expected performance. A visual image of the expected behavior facilitates the learner's comprehension and ability to duplicate the behavior or product. The presentation of visual aids such as a poster showing insulin injection sites or a videotape of proper injection procedures are ways of providing images. However, it is also becoming clear that behavior change is facilitated by the provision of role models (Bandura, 1977). The instructor's acting as a role model for the client will tend to increase the client's understanding and acceptance of the need to modify behavior. Weight Watchers has used this concept in its programming.

e. Learners should have opportunities to practice using the newly taught skills or knowledge and should receive feedback about their progress. The need for practice and feedback has been recognized by many health care practitioners who demand return demonstrations on newly learned skills (e.g., insulin injection).

f. The learner should be given the opportunity to design ways to adapt newly learned knowledge and skills to a different situation. This is particularly true when the environment in which the skills are being learned (the hospital) differs from the environment in which the skill will be practiced (the home). An illustration of the application of this principle involves using the equipment and conditions present in the learner's home for teaching diabetic foot care rather than using a standard tray of hospital equipment and supplies.

g. The emphasis should be on providing positive and satisfying learning experiences. Because the health care setting may be frustrating and frightening to the person whose communication skills within that environment are limited, the provision of a positive educational atmosphere may have a significant impact on the effectiveness of instruction. The student will be more highly motivated if (s)he first experiences success in the task.

3. Multiple Approaches

The use of more than one mode of or approach to instruction will assist in meeting the needs of various members of a population. Individuals respond differently to different forms of instruction. Even though a program cannot be absolutely individualized for each client, the use of multiple approaches increases the likelihood that a strategy will be used that appeals or is relevant to the learner.

A variety of instructional modes may be used in complement with one another. Mass media may be an effective way to introduce a topic, particularly if it is followed by more personal communication in order to facilitate behavior change. (Alcalay, 1980) In teaching psychomotor skills, a demonstration in person or via videotape followed by supervised practice will produce an effective teaching session. As mentioned earlier, the use of a role model should also encourage behavior change. (Bandura, 1977)

SUMMARY

In order to effectively educate a specific population, the needs and characteristics of the population must be assessed, the content of the program determined in consultation with members of the population, a faculty chosen who are culturally and/or otherwise appropriate, and a variety of methods used that consider the needs of the adult learner and the content of the material.

REFERENCES FOR EDUCATIONAL STRATEGIES

Alcalay, R. Rationale and Guidelines for Developing a Minority Health Communication Model. Paper written according to order #263-MD-013602-1, National Institute of Health, Washington, DC, 1980.

Baca, J. E., "Some Health Beliefs of the Spanish Speaking," American Journal of Nursing. 69:2172, Oct. 1969.

Bandura, A. Social Learning Theory. Englewood Cliffs, N.J., Prentice Hall, 1977.

Blackwell, J. E., and others. Health Needs of Urban Blacks. The Solomon Fuller Institute Research Report. Cambridge, MA: 1978.

Bolton, L. B. "Educational Program Provides Cross Cultural Health Care." Cross reference on human resources management. p. 5-7. May-June, 1981.

Brock, A. M., and O'Neal, D. J. "A Train the Trainers Workshop." Nursing Clinics of North America. 14:595. Dec. 1979.

California Conference on High Blood Pressure Control in the Spanish Speaking Community, Summary Report. U.S. Department of Health, Education, and Welfare, Public Health Service. National Institute of Health Publication number 79-1959. 1979.

Cole, K. editor. Minority Organizations: A National Directory. MD:Garrett Park Press, 1978.

Contract Report on Alternatives for Planning a Continuum of Care for Elderly American Indians, 1978. Report for National Conference on Health of Elderly Indians. Billings, Montana. August 16-18, 1978.

Director of Community High Blood Pressure Control Activities. U.S. Department of Health, Education, and Welfare, Public Health Service. DHEW Publication number (NIH) 77-1243. 1977.

Doak, L. G., and Doak, C. C. "Patient Comprehension Profiles: Recent Findings and Strategies." Patient Counseling and Health Education. p. 101-106. Third Quarter, 1980.

Dwyer, L. S., and Fralin, F. G. "Simplified Meal Planning for Hard-to-Reach Patients." American Journal of Nursing. 74:664, Apr. 1974.

Falck, V. T. "Planning Health Education for a Minority Group: The Mexican American. Intl. J. of Health Ed. 22:113-121. 1979.

Final Report of the National Black Health Providers Task Force on High Blood Pressure Education and Control. U.S. Department of Health and Human Services, Public Health Service. National Institutes of Health Publication number 80-1474, Oct. 1980.

First Conference on Hypertension among Puerto Ricans, Summary Report. U.S. Department of Health, Education, and Welfare, Public Health Service. National Institutes of Health Publicaion number 80-1962, Apr. 1980.

Fletcher, C. "Listening and Talking to Patients: IV Some Special Problems." British Medical Journal. vol. 281, Oct. 18, 1980.

Foley, R. P., and Smilansky, J. Teaching Techniques for Health Professionals. New York City: McGraw Hill, 1980.

Friere, P. Pedagogy of the Oppressed. New York City, The Seabury Press, 1968.

Health Education and the Mexican American. The University of Texas Health Science Center at Houston, Division of Continuing Education, Center for Disease Control, Bureau of Health Education, #200-75-0568, 1977.

The Health of Mexican-Americans in South Texas. A Report by the Mexican-American Policy Research Project. The LBJ School of Public Affairs. The University of Texas at Austin. 1979.

Identification of Problems in Access to Health Services and Health Careers for Asian Americans. DHEW, Public Health, HRA, Office of Health Resources Opportunity, 1976.

Jennings, A. L. The Delivery of Primary Health Care in the Inner Cities: It's Users, Services, Problems. U.S. Department of Health, Education, and Welfare, Public Health Service, National High Blood Pressure Education Program, Nov. 1979.

Knowles, M. S. The Adult Learner: A Neglected Species, 2nd ed., Houston, Gulf Publications, 1978.

Lee, I. C. Medical Care in a Mexican American Community. Los Alamitos, CA: Hwong Pub. Co., 1976.

National High Blood Pressure Education Program's Minority Effort, Five Year Assessment, (working draft) Apr. 1980.

National Symposium on High Blood Pressure Control in U.S. Asian/Pacific Populations, Summary Report. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health Publication number 80-1609, Dec. 1979.

"Nutrition Education Geared to Patients who have had minimal schooling." Hospitals, J.A.H.A. 51:14-15, July 1, 1977.

Press, C. M., Jr. "The Approach of Health Care in Three American Minorities." in Bille, D. A. ed. Practical Approaches to Patient Teaching, p. 85-94. Boston: Little Brown & Co., 1981.

Proceedings of the National Conference on High Blood Pressure Control in Native American Communities. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, Bethesda, MD. NIH Publication number 79-1960, Aug. 1979.

Ramirez, A. and Lasater, T. M. "Ethnicity of Communicator, Self Esteem, and Reactions to Fear-Arousing Communications." Journal of Social Psychology. 102:79-91, 1977.

Review and Response to the Final Report of the National Black Health Providers Task Force on High Blood Pressure Education and Control. U.S. Department of Health Publication no. 80-2187, 1980.

Roter, D. L., and others. "Community-Produced Materials for Health Education." Public Health Reports. 96, no. 2, Mar.-Apr. 1981. p. 169-172.

Sanders, C. L. editor. Mental Health Programs for Racial Minorities. Summary and papers from National Conference on Mental Health Programs for racial minorities--needs and directions. Mental Health Research and Development Center, Institute for Urban Affairs and Research, Howard University, Washington, D.C., Feb. 10-12, 1977.

Sharpley, R. H. Foreign Medical Graduates and Black Patient Populations. Solomon Fuller Institute, MA Round Table Conference Report, 1977.

Suren, J. V. "Education of the Culturally and Educationally Deprived Diabetic." Nursing Clinics of North America. 12:427-437, Sept. 1977.

Welch, S., and others. "Some social and attitudinal correlates of health care among Mexican Americans." Journal of Health and Social Behavior. 14:205-213, 1973.

SECTION III

RECOMMENDATIONS OF ORGANIZATIONS AND INDIVIDUALS WORKING WITH SPECIAL PATIENT GROUPS

In the specific area of health education for various cultural groups, it is important to examine relevant statements of organizations that represent and/or work with these cultural groups. This section of the document categorizes some of the health education recommendations of such organizations; it is not meant to be an exhaustive presentation of the statements of all groups that have addressed these topics nor does it attempt to present all that has been said about the issues. Finally, although the organizations whose statements appear in this section represent only minority cultural groups, many of their recommendations can also be used as the basis for enhancing health education for patients with low literacy skills or with hearing and visual impairments.

Federal funding has assisted the development of some of these recommendations by way of incentives for groups to meet and discuss the state of health care for various cultural groups. In other instances, government organizations or agencies organized the meetings that were precursors to some of the documents that have been examined for this paper. The documents that have been included because they have clear implications for health education are listed at the end of this section.

The recommendations that have been gleaned from these documents can be organized into the following five categories: (1) organizational concerns, (2) materials development, (3) staff education, (4) dissemination of materials and information, and (5) funding. A brief discussion of these categories is presented below.

Organizational Concerns. The most immediate and most frequently mentioned organizational issue was that health education should become an integral part of the health care system, rather than be viewed as optional or less important than direct patient care. The groups also considered coordination of ideas and communication of health education activities as very important. They suggested that legislation and support for health education could be facilitated by a coordinated effort for groups with special health education needs. Cooperative efforts among community groups towards seeking funding were also recommended.

Members of the cultural groups indicated a need for trained health professionals of their own culture and recommended increasing the number of trained bicultural health care professionals. One suggestion for accomplishing this goal was to establish a career promotion process for bicultural paraprofessionals. The development of skills relevant to the needs of the particular population would be emphasized in such a program. A related recommendation was that practitioner staffing patterns should reflect the cultural background of the users of a health care facility.

The groups' discussions recognized the need for community involvement in a successful health education effort. In particular, they emphasized that as many relevant community organizations as possible should participate in some way in the program planning process. It was further recommended that health care professionals should be active participants in the community they seek to serve. Such participation increases the health professional's awareness of the needs of the population, enhances the credibility of the professional with the community members, and enables the professional to act as an advocate for consumers. It was also suggested that health education be made available in nontraditional settings such as churches and shopping centers in order to reach larger numbers of the populations.

Materials Development. A number of recommendations emerged regarding materials development. One common theme was the need for materials (print and audio-visual) that demonstrate cultural awareness. Specifically, materials should be adapted so they are "culturally accurate, educationally appropriate, and culturally sensitive." ("Health Education and the Mexican American," 1977) Some groups suggested that print materials be available in the native language, although not all groups found this necessary. It was also suggested that a directory or clearinghouse for culturally specific health education materials and programs is desirable.

Staff Education. Recommendations regarding this issue focused on the need for staff to be informed about and sensitive to the cultural uniqueness of each group they seek to serve. Such sensitivity would consider the adaptions that must be made in health education materials to accommodate cultural differences (for example, religious and/or cultural beliefs and practices, differences in sex roles, and nutritional preferences). It was recommended that nursing, allied health, public health, and medical schools should be responsible for training health professionals to be aware of the particular demands that transcultural populations are likely to make on health care settings. It was also strongly indicated that some form of continuing education be provided that would increase staff members' awareness of the needs of particular groups and help establish effective ways of meeting these needs.

Dissemination of materials and information. Many of the advisory groups requested that information about effective models or model programs be developed and disseminated. They also called for increased efforts to disseminate health education materials to cultural or other specific groups. Such efforts could include the use of minority media, community-based health organizations, and the local affiliates of national fraternities, religious, and social organizations (for example, the Masonic organization), which could act as possible channels of communication and dissemination of information.

Funding. The need for monetary resources is implicit in many of the above recommendations. Specific recommendations include the need for third party reimbursement, for funds to support the development of multimedia and other educational materials for specific cultural groups, and for evaluation.

Implementation of the above recommendations must come in a variety of ways. It is hoped that this document will facilitate the implementation of some of the recommendations regarding staff education and dissemination of information.

SOURCES OF RECOMMENDATIONS

Blackwell, J. E., and others. Health Needs of Urban Blacks. The Solomon Fuller Institute Research Report. Cambridge, MA: 1978.

California Conference on High Blood Pressure Control in the Spanish Speaking Community, Summary Report. U.S. Department of Health, Education, and Welfare, Public Health Service. National Institutes of Health Publication number 79-1959. 1979.

Contract Report on Alternatives for Planning a Continuum of Care for Elderly American Indians, 1978. Report for National Conference on Health of Elderly Indians. Billings, Montana. August 16-18, 1978.

Final Report of the National Black Health Providers Task Force on High Blood Pressure education and Control. U.S. Department of Health and Human Services, Public Health Service. National Institutes of Health Publication number 80-1474, Oct. 1980.

First Conference on Hypertension among Puerto Ricans, Summary Report. U.S. Department of Health, Education, and Welfare, Public Health Service. National Institutes of Health Publication number 80-1962, Apr. 1980.

Health Education and the Mexican American. The University of Texas Health Science Center at Houston, Division of Continuing Education, Center for Disease Control, Bureau of Health Education, #200-75-0568, 1977.

The Health of Mexican-Americans in South Texas. A Report by the Mexican-American Policy Research Project. The LBJ School of Public Affairs. The University of Texas at Austin. 1979.

Identification of Problems in Access to Health Services and Health Careers for Asian Americans. DHEW, Public Health, HRA, Office of Health Resources Opportunity, 1976.

Jennings, A. L. The Delivery of Primary Health Care in the Inner Cities: It's Users, Services, Problems. U.S. Department of Health, Education, and Welfare, Public Health Service, National High Blood Pressure Education Program, Nov. 1979.

National High Blood Pressure Education Program's Minority Effort, Five Year Assessment, (working draft) Apr. 1980.

National Symposium on High Blood Pressure Control in U.S. Asian/Pacific Populations, Summary Report. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health Publication number 80-1609, Dec. 1979.

Proceedings of the National Conference on High Blood Pressure Control in Native American Communities. U.S. Department of Health, Education, and

Welfare, Public Health Service, Natinal Institutes of Health, Bethesda, MD. NIH Publication number 79-1960, Aug. 1979.

Review and Response to the Final Report of the National Black Health Providers Task Force on High Blood Pressure Education and Control. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health Publication no. 80-2187, 1980.

Sanders, C. L. editor. Mental Health Programs for Racial Minorities. Summary and papers from National Conference on Mental Health Programs for racial minorities--needs and directions. Mental Health Research and Development Center, Institute for Urban Affairs and Research, Howard University, Washington, D.C., Feb. 10-12, 1977.

Sue, S., and Chin, R. National Asian American Psychology Training Conference. Seattle: University of Washington Publication Press, 1977.

SECTION IV

RECOMMENDATIONS APPLIED: AN EXAMPLE OF A PATIENT INTERVIEW

The following patient interview does not indicate the presence of a translator nor any significant difficulty with oral communication between a patient and a physician; in that sense, it does not represent all the culturally-bound parameters that a clinician may be dealing with in many interchanges with patients from cultural minorities. Nevertheless, it is a good example of the kind of sensitivity to a patient's cultural attitudes that can help establish trust and cooperation and reveal the complexity of causes to a patient's health complaints.

PATIENT INTERVIEW
OF
A 45-YEAR OLD WOMAN WITH HEADACHES

A 45-year old Mexician-American woman responds when the name, Marie Flores, is called out in a crowded clinic waiting area. She appears deferential as she is ushered into an uninviting, institutional green examination room by a smiling physician, identifiable only by his countenance, a medical chart in his hand, and his shirt and tie. The two have never met, although the patient has been to the clinic several times before and the physician has worked there for three years. Upon reaching the examination room doorway, Mrs. Flores seems perplexed by her doctor's outstretched hand and finally grasps it only because he persists in this attempt to reach out, evidently a foreign experience to her. As she sits by his formica desk in a small vinyl chair, she glances warily at a crumpled sheet, pushed to the bottom of the examination table from a previous patient. The examination table is wedged into the only corner of the room in which it will fit. Still, the doctor evinces an unharried air, and his expression seems to connote geniune interest in her. The interview thus begins with a certain sense of surprise and hopeful expectancy.

Doctor: Hello, Mrs. Flores, I'm Doctor Paultz. I'm sorry you had to wait so long today.

Patient: Oh, that's OK.

D: Can you tell me what the main problem is that made you come to the clinic?

P: Headaches.

D: Can you tell me about them?

P: Well, they just hurt...I mean I don't know what's causing them...and I feel kind of silly coming to a doctor...

D: You feel silly?

---

*Reprinted with permission from: David E. Reiser and Andrea K. Schroeder. Patient Interviewing: the Human Dimension (Baltimore: Williams and Wilkins, 1981), p. 222-229.

P: Well, I usually only go to the doctors for colds and things, and...well, I'm never sick!

D: It must be difficult for you to be here then.

P: Yes.

D: These headaches must concern you.

P: Well, they don't go away.

D: Can you tell me what the pain feels like?

P: I get this hard pain in the back of my head.

D: Hard pain? Can you be more specific?

P: It feels like someone is putting a band around my head and tightening it at the back, right here.

D: Does the pain move anywhere?

P: Yes, into my neck and around the side into my...over here, my temples.

D: When did this first start?

P: About three months ago.

D: How often do the headaches come?

P: At the start they happened about once a week, but lately it's everyday.

D: How long does one last once it starts?

P: Anywhere from one hour to all day.

D: Do the headaches ever last several days without relief?

P: Yes, it was there for a solid week about a week ago.

D: You mean day and night without relief?

P: Yes.

D: That must have been very upsetting.

P: (Tears well up in Mrs. Flores' eyes.)

D: I can see that this has been very upsetting to you. It's all right to cry (handing the patient a tissue). Have you been able to share your feelings with anyone else?

P: (Shakes head, "no.")

D: Well, I'm glad you can do it now. It's very important to express your feelings. It can help.

P: I'm just afraid of what this could be...

D: What are you thinking of?

P: Oh, I don't know. Different people say things...
D: Like what?

P: Oh, you know...Like it could be something bad...

D: Like...?

P: Oh...like cancer, or something.

D: We shouldn't jump to any conclusions. Nothing you've said so far makes me think of cancer; if we can work together, I think we can find a cause for your problem. Let's get back to the pain for a moment. You said the pain was there for a whole week a short time ago?

P: Yes.

D: If you look back over the three months, would you say the pain is worse now than it was when it started, the same, or better?

P: Worse.

D: In what way?

P: It's there all the time now, just about.

D: Has the feeling of the pain itself changed during the three months?

P: No, it feels about the same when it comes.

D: What can you do to relieve it?

P: Sit in a hot bathtub.

D: What else?

P: Aspirin used to help, but it doesn't seem to touch it anymore.

D: Have you tried anything else?

: Not really...

D: What makes it worse or brings it on?

P: Sometimes nothing. Sometimes when I get angry or worried.

D: What kinds of things make you feel like that?

P: I don't know.

D: But you know when you're feeling angry or worried?

P: Sure.

D: Have you been to any other doctors for these headaches?

P: Yes, they said it wasn't anything!

D: What do you mean?

P: I had to go to the emergency room last week, and they said it was my nerves.

D: What did you think about that?

P: Well, I didn't think nerves could make a person hurt so much.

D: Did you say that to the emergency room doctor?

P: No, he was in too big of a hurry!

D: Did they do any tests on you?

P: Uh...I think they took an x-ray and a blood test.

D: Did you find out the results?

P: I guess they were O.K. They never said anything about them.

D: Do you have any other symptoms during the headaches?

P: I feel dizzy.

D: Describe the dizziness.

P: Kind of drunk in the head.

D: Does the room ever feel like its spinning with your dizziness?

P: No, I had that a long time ago.

: How long ago?

P: Oh, just for a day...they said it was due to a virus. It was 10 years ago.

D: Do you have any symptoms with the headaches besides dizziness?

P: No.

D: What about difficulty with vision?

P: I wear glasses.
D: I mean, does your vision change during the headaches?

P: Not really.

D: What about nausea?

P: No.

D: Fainting spells?

P: No.

D: Numbness in any part of your body?

P: No.

D: Fever?

P: No.

D: Has this problem affected your appetite?

P: (Laughs self-disparagingly.) I don't think so! (Looks down at plump midriff.) I wish it would!

D: You mean you haven't lost any weight?

P: Right!

D: What about sleeping...have you had any difficulty sleeping?

P: You mean because of the pain?

D: Yes.

P: No. I can always go to sleep...even with the headaches.

D: I got the notion that you were having some sort of sleeping problem, the way you answered that.

P: Well, I can't sleep all night.

D: What do you mean?

P: Well, I wake up and have a lot of trouble getting back to sleep.

D: Why do you think that is?

P: I don't know.

D: Is it due to the headaches?

P: No.

D: Well, some people who can't sleep are afraid to go to sleep...they are afraid they'll die. Do you ever have that feeling?

P: Sort of.

D: Do you have dreams while you sleep?

P: Sometimes. I think I have one sometimes. It seems like I remember it when I first wake up.

D: Can you share the dream with me?

P: Well, I can't remember it too well.

D: Do the best you can. I think it will be helpful.

P: There's this dream...

D: Does it recur?

P: Yes.

D: How many times have you had it?

P: About four or five times in the past six months.

D: Tell me about it if you can.

P: I see my grandmother, and some other people.

D: Is your grandmother dead or alive?

P: She's dead.

: When did she die?

P: Two years ago.

D: What do you see in the dream?

P: Well, everyone is walking around a big table...that has a lot of food on it.

D: Can you see the look on the people's faces?

P: No, but my grandmother turns to me and points my way.

D: What is she trying to do?

P: She wants me to come to the table with her.

D: What happens then?

P: I don't want to go...I get very scared...

D: Does the dream end there?

P: Yes, I usually wake up...

D: And have trouble getting back to sleep?

P: Yes.

D: Do the dreams have anything to do with the headaches?

P: I don't know...I don't think so.

D: I really feel like I'm getting to know you better, and I have more of a feeling that we can find out what's causing these headaches, but I need to ask some more questions to get to know you a little better.

P: Go ahead!

D: Are you from Denver?

P: No, from Trinidad (Colorado).

D: Did you grow up there?

P: Yes, but we used to spend a lot of time in Cortez (Colorado), too.

D: Who is we?

P: My sisters, my mother, and I.

D: What about your father?

P: I didn't really know him. They say he died when I was very young.

D: Did your mother raise you?

P: Not really.

D: Who did?

P: My grandma and her husband.

D: Where were they from?

P: Cortez. But, they really came from old Mexico.

D: Do you remember much about the times with your grandmother?

P: Sort of.

D: What did your grandmother usually do when you kids were sick?

P: She'd usually take care of it herself.

D: In what way?

P: Home remedies.

D: Do you mean herbs and things like that?

P: Sometimes.

D: Do you remember much about that?

P: Well, I know that she used to believe in the spirits very strongly.

D: What did you think about that?

P: I was just a little kid.

D: But what do you think now about it?

P: Oh, people say you can get sick that way.

D: What way do you mean?

P: (Hesitantly)...Oh, with prayers and the like.

D: Do you believe that?

P: I guess it's possible.

D: Do you remember your grandmother going to a special healer for herbs and prayers?

P: Yes, she went to a curandera in Cortez.

D: Did you ever go?

P: No.

D: But you know that she went?

P: Yes.

D: For what?

P: Oh, to get herbs.

D: Anything else?

P: Well, my aunt had a problem.

D: What kind of a problem?

P: Oh, I can't really talk about it.

D: You know, I understand that most Anglo doctors only treat sickness the way they are taught...but I have had some experience with the kind of illness we are talking about here. I know about what your people call the "special knowledge"...about the white and black magic, about brujas (witches). Was your aunt imbrujada (bewitched)?

P: They said she was.

D: Do you know who the bruja or brujo was?

P: They used to talk about her sister-in-law.

D: What did they say?

P: They said she was a bruja!

D: How did they know?

P: They always saw her around the house, and one day my aunt said a plate of noodles turned into worms! And it was right after this lady (the bruja) had been near the house.

D: What else?

P: This lady, she would come over at night and pluck one of my uncle's hairs, but each time she did it, she would turn a little older...you could see it in her face.

D: Did your grandmother try to help your aunt with the curandera?

P: Yes. They said prayers over my uncle.

D: Did they help?

P: Well, for a while.

D: What do you mean?

P: My uncle used to get very sick. They never found out what was wrong with him. I guess it was his gallbladder or something. Then he started to drink...he never stayed at home.

D: Did he leave your aunt?

P: Yes.

D: Because of this lady?

P: She was really jealous of my aunt for taking her brother.

D: Do you know if he got better after he left your aunt?

P: I think so...I don't know where he is now.

D: What about the bruja? Where is she?

P: I don't know if she is even around anymore.

D: Your aunt must have suffered a lot.

P: Yes, and my mother.

D: In what way?

P: She always hated that lady!

D: Was she good friends with your aunt's husband?

P: Yes.

D: Did your mother ever get sick because of the bruja?

P: I don't know.

D: Where is you mother now?

P: She died when I was eight years old.

D: Of what?

P: I don't know.

D: Is it possible the bruja was responsible?

P: I think so!

D: That must be quite frightening to you!

P: Well, my grandmother told me never to worry about that lady.

D: Were you able to follow her advice?

P: I think so.

D: What about the dream you have?

P: I'm not sure...

D: Is it connected to the bruja?

P: Maybe.

D: Has anyone told you, or have you thought it yourself ... that maybe a curandera could help your headaches?

P: Yes ... my sister said so, but I don't know ... I'm not sure ... and I don't know of any curanderas.

D: What if I told you that I know one who I work with, who can talk with people and find out if they are imbrujada?

P: That would be good.

D: I'm thinking that the dream, the headaches and your memories about the lady in Cortez may be related. Do you think that is possible?

P: It could be.

D: I will set up an appointment with the curandera, if that's OK with you ... and perhaps we can find out about any connection between these different things. But I still need to do a complete physical, some lab work, and a more complete history before we come to a final conclusion. Today, I want to do a partial physical to answer some questions I have about your headaches.

P: OK.

The physician does a problem oriented physical exam that includes examination of the head, eyes, ears, nose, and throat as well as a check of vital signs and a neurologic examination. Following the examination (which was totally normal except for tenderness of the scalp muscles) the interchange continues.

D: There, that wasn't too bad, was it?

P: No!

D: Well, why don't we make another appointment for a week or so. We really need to help you with your headaches. At the same time we'll have your evaluation by our curandera.

P: OK.

D: It's been nice working with you today. I'm confident we'll get to the bottom of this.

P: Me too.

D: Good bye.

P: Good bye, thanks.

D: You're welcome.

The physician's problem list, assessment and plan appeared in the medical record like this:

Problem #1-Occipital Headaches
Assessment: The location of the pain, rather constant time/intensity curve over several months, persistence over days without relief, response to sleep, and the significant psychogenic factors (see Problem #2) suggest that this is a muscle tension headache. There seems to be no evidence by history or physical for vascular headache, sinusitis or a space occupying lesion with increased intracranial pressure. She is probably too young for temporal anteritis and the location of the pain and lack of temporal tenderness rule against this.
Plan:
  Diagnostic: Finish history and physical.
    Basic lab profile.
    Work-up problem #2.
  Treatment: No further Rx at present. Consider unified Rx approach with problem #2 to watch therapeutic response. Will consider relaxation training and analgesis next visit.
  Patient Education: Work-up explained to patient. Consideration of link between psyche and organic disease begun.

Problem #2-Sleep Disturbance/Ethnomedical Problem

Assessment: Regardless of the organic nature of the headaches, the patient's cultural beliefs need attention in the total approach to her problems. This is true regardless of the culture. Her belief system seems well founded in her early childhood experiences, but her attachment to this cultural belief system, and therefore its relevance to problem #1, remains to be demonstrated. In support is her sleep disturbance, which has many of the elements of an Indian "ghost illness," i.e., dreaming of decreased persons who beckon the subject to join them. There is often unresolved guilt at the source, and one wonders if grandmother-mother relationship caused ambivalence in our patient, and also whether the patient's fears re: the grandmother being imbrujada as a result of battles with the bruja caused the patient to reject the grandmother. This could explain unresolved guilt or fears that the patient became imbrujada after the grandmother's death. The Indian-Chicano mix here is consistent with the cultural explanation for illness in the Cortez, Colorado area, and any ethnomedical treatment would necessarily be directed at the cultural expectation most embraced by the patient. In any event, the cultural influence on this patient's headaches is strongly suggested and must be considered along with the organic aspects of her problems.

Plan:

Diagnostic: Consultation with the clinic's curandera.

Treatment: To be determined following consultation.

Patient Education: This process explained to patient as part of the medical interview. I will attempt to facilitate her understanding on future visits.

SECTION V

RESOURCES FOR HEALTH EDUCATION OF SPECIAL GROUPS

References on Transcultural Issues

Bullough, B. and Bullough, V. Poverty, Ethnic Identity and Health Care, (New York: Appleton-Century Crofts, 1972).

Discusses issues in health care delivery for selected groups (i.e., immigrants, Black Americans, Hispanics, and Native Americans). The book focuses on poverty, discrimination, and segretation as leading factors in preventing improvement of health care. Writing from an historical perspective, the authors suggest the importance of recognizing the impact of these factors on health care and the need for health professionals to be sensitive to these issues.

Crandall, L. A. and Duncan, R. P. "Attitudinal and situational factors in the use of physician services by low-income persons," J. Health Soc. Behavior, 22:64-77, March 1981.

Reports that income level is less of an influencing factor than attitude in health care utilization among low-income Americans. Also indicates that trust of physician is negatively correlated to the use of services, whereas belief in the effectiveness of orthodox medical care is positively correlated with use.

Glittenberg, J. "Adapting Health Care to a Cultural Setting," Amer. J. Nursing, December, 1974, p. 2218.

Describes a health clinic in Guatamala and one doctor's attempt to adapt and incorporate traditional medical practices and practioners into the clinic's system. He found that this approach improved the client's attitudes toward orthodox health care and was effective in promoting positive change in the health status of the village. The traditional health practitioners were trained as assistants in the clinic. Thus, the client's need for both traditional and orthodox types of treatment was recognized as crucial.

Henderson, G. and Primeaux, M. Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981).

A series of articles discussing factors that prevent effective health care delivery to cultural minorities. Suggests methods to improve health care through sensitivity to the culture group's traditional health practices and discusses how cultural issues such as diet, family structure, and religion impact on health care. The groups discussed are Asian-Americans, Blacks, Hispanics, and Native Americans; issues specific to each group are presented.

Klein, N., ed., *Culture, Curers and Contagion*, (Novata, CA: Chandler & Sharp Pb., Inc., 1979).

Discusses the diversity in health care among cultures. It includes differences in perceptions of health and illness and the challenge this presents to health care professionals in a multi-ethnic society. Topics covered are culture and contagion, the ecology of health, patients and practitioners, health care in a pluralistic society, and health belief systems. Readings are not limited to U.S. cultures but rather include some examples from other countries.

Kleinman, A. and Sung, L. "Why do indigenous practitioners successfully heal?" *Soc. Sci. & Medicine*, 13B:7-26, 1979.

Recognizing the radical discontinuity between traditional and orthodox health care, the authors related findings from studies of patients treated by Chinese shamans to determine the efficacy of traditional healing practices. They found that shamans were often effective when treating psychosocial problems but less effective in treating life-threatening illnesses. They also found that clients who sought traditional care for psychosocial concerns often sought orthodox medical care for more serious physical illnesses.

Leininger, M., *Transcultural Nursing Concepts, Theories and Practices*, (New York: John Wiley & Sons, 1978).

A series of articles by health care professionals addressing areas of nursing health care such as theories and research approaches to transcultural nursing. It also discusses the meaning and significance of culture in relation to transcultural nursing. The book stresses the need for knowledge of cultural differences such as beliefs and practices concerning food, medicine, child-rearing, and aging. Presents examples of various ethnic groups.

Orque, M. S. "Health Care and Minority Clients," *Nurs. Outlook* 24(5):313, May, 1976.

Describes a sensitivity tool designed for a course in nursing health care of ethnic minorities. It provides student nurses with an opportunity to become sensitive to cultural differences by identifying factors unique to different groups.

Quesada, G. M. "Language and Communication Barriers for Health Delivery to a Minority Group," *Soc. Sci. Med.*, 10:323-327

Explains and interprets some of the areas in which misinterpretation of cultural values by both clients and clinician can lead to conflict and a breakdown in communication. He points out how mother tongue language shapes the social and cognitive reality of the individual. Communication and language play a significant role in health care delivery. Recommends that language crash courses for health professionals are not enough but rather seminars, lectures and programs on cross-cultural interaction can be very helpful. He also recommends the utilization of folk medicine and faith healers as paraprofessionals, because they already have the cultural understanding and confidence of the clients from the ethnic group.

Suren, J. V. "Education of the culturally and educationally deprived," Nurs. Clinics of N. Amer., 12(3):427, Sept. 1977.

Describes an outpatient education program for the economically deprived diabetic. The article discusses some of the psychosocial issues of poverty and health care and the client's feelings of powerlessness and lack of control of live and the environment. The feelings are viewed as contributing factors in non-complience to medical regimens. Six weekly classes are conducted to educate the patient about the disease process. One of the goals of the class is to improve patients' self-concept by increasing their knowledge about the disease process and how a diabetic can control it. In this way, the client gains more control over the illness and indirectly over one aspect of her/his life.

Weidman, H. "The Transcultural view: prerequisite to interethnic (intercultural) communication in medicine," Soc. Sci. Med., 13B:85-87.

Emphasizes the unconscious assumptions by orthodox health professionals that value complex medical technological achievement and devalue traditional or folk belief and medical systems. Points out that these assumptions sanction disregard of the client's cultural/medical orientation. Promotes a health culture approach to medicine in order to better serve a multiethnic population. A unicultural approach to medicine forces the client to adapt to the system of the clinician and undermines the client's belief system, forcing her/him to unquestionly accept a scientific medical approach. Such a perspective inhibits identification of health care problems of ethnic minorities.

Non-Annotated Bibliographic Sources

Atkinson, D., Morten, G., and Sue, D., Counseling American Minorities (Dubuque, IA: Wm. C. Brown Company, 1979).

Bullough, B. "The expanding role of the R.N.," in J. R. Folta and E. S. Deck, eds., A Sociological Framework for Patient Care (New York: John Wiley and Sons, 1979) p. 142.

----, B. and V. L. Bullough, Poverty, ethnic identify and health care, (Des Moines, IA: Meredith Corp., 1972).

Branch, M. F., and P. P. Paxton, eds., Providing Safe Nursing Care for People of Color, (N.Y.: Appleton-Century-Crofts, 1976).

Brink, P., Transcultural Nursing, (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1976).

Brinton, D. M., "Value differences between nurses and low-income families," Nurs. Res., 21:46-52, Jan.-Feb., 1972.

Dutton, D. B., "Explaining the low use of health services by the poor: costs attitudes or delivery systems," Amer. Soc. Review, 43:348-68, 1978.

Greenley, J. R. and Schoenberr, R. A. "Organization effects on client satisfaction with humaneness of service," J. Health Soc. Behavior, 22:2-18, March, 1981.

Henderson, G., ed. Understanding and Counseling Ethnic Minorities, (Springfield, IL: Charles C. Thomas Pb., 1979).

Hinton, T. and Johnson, K. "Creating an atmosphere for positive behavior change in a hypertension education program with emphasis on cultural and attitudinal variables," (Detroit, MI: Comprehensive Health Services, n.d.).

Kolers, P. A., "Bilingualism and information processing," Contemp. Psych. 1971.

Kosik, S. H., "Patient advocacy or fighting the system," Amer. J. Nurs., 72:694-698, Apr. 1972.

Landy, E. ed., Culture, disease and healing: studies in medical anthropology, (New York: Macmillan, Inc., 1977).

Landy, D., "Role adaptation: traditional curers under the impact of western medicine," in Logan and Hunt, eds. Health and the Human Condition: Perspectives in Medical Anthropology, (North Scituate: Duxbury Press, 1978).

Leininger, M., "Cultural diversities of health and nursing care," Nurs. Clin. N. Amer. 12(1):5-18, March 1977.

________, Nursing and anthropology: two worlds to blend, (New York: John-Wiley and Sons, Inc. 1970).

________, Using cultural styles in the helping process and in relation to the subculture of nursing, (Chicago: Nursing Papers, State of Illinois, 1972), p. 43.

Moore, B. M., "Cultural differences and counseling persepctives," Texas Personnel Guid. Assoc. J. 3:41, 1974.

Mosley, D., "The nursing profession and the urban poor," NCRIEED Tipsheet 11:2-3, 1973.

National Center for Health Statistics (NCHS), "Health characteristics of minority groups, United States, 1976," Advance Data 27 (April 14), 1-8, 1978.

"Race, Education and Prevalence of Hypertension," Amer. J. Epidemiology, 106(5):351-61, Nov. 1977.

Randall, T. G. and Wheller, J. R. C. "The effect of income on use of preventive care: An evaluation of alternative explanations," J. Health Soc. Behavior, 20:297-406, 1979.

Robertson, H. R., "Removing barriers to health care," Nurs. Outlook 17:45, 1969.

Segall, A., "Socio-cultural variation in sick role behavioral expectations," Soc. Sci. Med., 10:47-51, 1976.

Sotomayer, M., "Language, culture and ethnicity in developing self-concepts," Social Casework, 58:195, 1977.

Spector, M. Cultural diversity in health and illness, (New York: Appleton-Century-Crofts, 1979).

Strauss, A. L., "Medical organization, medical care and lower income groups," Soc. Sci. Med., 3:143-177, 1969.

Weaver, J. L. and Inui, L. T. "Information about health care providers among low-income minorities," Inquiry, 12:330-43, Dec. 1975.

White, E. H., "Giving health care to minority patients," Nurs. Clin. N. Amer., 12(1):27-40, March 1977.

Wilson, R. N., The Sociology of Health: An Introduction, (New York: Random House, 1970).

REFERENCES ON AMERICAN INDIANS

Barrow, M. V., Niswander, J. D. and Fortuine, R. Health and Disease of American Indians North of Mexico A Bibliography 1800-1969, (Gainesville, FL: Univ. of Florida Press, 1972).

Purposely omits bibliographic sources concerning folk medical beliefs and anthropological studies. However, it does include a comprehensive coverage of health programs for Indians. Among other categories are infectious agents and diseases, diet, nutrition and growth; physiology and metabolism; and environmental health issues.

Bozof, R. P., "Some Navajo attitudes toward available medical care," AJPH, 62(12):1620, December 1972.

Conducted a survey in an outpatient clinic to determine patterns in attitudes towards three kinds of health care: 1) that of private physicians; 2) that provided by the Public Health Service, and 3) that provided by Navajo medicine men. The study revealed no conflict on the part of Navajo in using both traditional and PHS medical services. It also found that private doctors gave more shots than PHS, and that this method increased patients confidence in western medicine.

Camazine, S. M., "Traditional and western health care among the Zuni Indians of New Mexico," Soc. Sci. Med., 14B:73-80, 1980.

This important and informative article discusses the coexistence of traditional and western health care practices among the Zuni. The author points out the influence of western health practices on change of traditional medicine practices. He provides examples of traditional medical beliefs and treatment. He also discusses the important role of the ak'wa:mossi (the native healer) as both medical practitioner and as agent in cultural maintenance. Specific examples of health practices address childbirth, elipesy, and diabetes as well as herbal remedies used to treat these conditions. Traditional medicine persists because of its cultural basis and holistic approach to health. In addition it provides effective psychological treatment, minimizes fears of the patient, and contributes to social control and norm adherence. These practices can complement orthodox medicine and can be helpful in promoting greater adherence to orthodox medical regimens.

Goins, R., "Hypertension management in American Indian Communities," (Rapid City: South Dakota United Indian Assoc., n.d.).

Hypertension is a significant factor in American Indian morbidity and mortality rates. Factors preventing hypertension screening and health care programs include isolation of reservations and scattered populations in urban areas. The author outlines treatment approaches from a non-Indian perspective as well as a traditional approach from an Indian culture perspective. In Indian medicine, psysiological, psychological, and environmental factors are interrelated and included as part of the treatment.

Primeaux, M., "Caring for the American Indian Patient," *Amer. J. of Nursing*, January, 1977, p. 91.

An excellent and informative article on the relationship between Indian values and Anglo health care. Primeaux points out that Indian cultural values and behaviors can be misinterpreted by the Anglo clinician. She cites examples of Indian medical care rituals. She suggests that clinicians draw family members into health care by sharing tasks. Expressing the need to incorporate medicine men and practices into the health care, she cautions that agreement between orthodox and Indian medical professionals should be made as to the kinds of drugs prescribed by both to avoid incompatibility.

---, "American Indian health care practices," *Nurs. Clin. N. Amer.*, 12(1):55, March, 1977.

Provides an example of cross-cultural conflict and points out that there are usually reasons why an individual's behavior, which may seem inappropriate to a practitioner of a different culture, may be explained by psychological, sociological, and/or cultural reasons.

Yukl, T., "Caring for the urban American Indian patient," *J. Emer. Nursing*, 7(3):110, May/June 1981.

Describes the "typical" urban Indian patient as male, isolated from his culture, and alienated from his environment. For this reason he often resorts to alcohol. Indicates that cultural differences between client and clinician can further alienate the client who seeks medical care. Points out some areas where conflict can occur. Recommends that health professionals establish working relationships with local Indian centers and with the Indian communities and be aware of available alternatives for Indians, such as walk-in clinics where no appointments are necessary.

Steward, T. *et al.* "A Navajo health consumer survey," *Medical Care*, XVIII(12):1183, December, 1980.

Survey of 1976-77 found that basic services (sewage, water, electricity), lack of quick access to health care facilities due to location and inability to acquire transportation, attitudes about the Public Health Service facilities, and language barriers were factors in underutilization of health care. Also showed that Navajo have pragmatically incorporated western values and beliefs toward medicine into their lifestyle, demonstrating that cultural beliefs and values are less of a barrier than are obstacles in methods of providing health care delivery.

Non-annotated Bibliographic Sources

Backup, R. W., "Implementing quality health care for the American Indian patient," *Wash. State J. Nurs.*, 1979: Supplem. 20-24.

Goins, R. "Comparative Cultural Values," and "Wookahing (Understanding)," (Rapid City: South Dakota Indian Association, n.d.)

Isaacs, H. L., "American Indian medicine and contemporary health problems. Toward improved health care for Native Americans--Comparative perspective on American Indian medicine concepts," *NY State J. Med.*, 78(5):824-829, April 1978.

Judkins, R. A., "American Indian medicine and contemporary health problems. Diabetes and perception of diabetes among Seneca Indians," *NY State J. Med.*, (8):1320-3, 1978.

Mealey, S. A., and Kane, R. L., "Factors that influence Navajo patients to keep appointments," *Nurs. Pract.*, 2(4):18-22, March-April, 1977.

Primeaux, M., "American Indian health care practices: a cross-cultural perspective," *Nurs. Clin. N. Amer.*, 12(1):55-65, March 1977.

---- "American Indian Patient Care," in Henderson G. and M. Primeaux, *Transcultural Health Care*, (Menlo Park, CA: Addison-Wesley, 1981).

Proceedings of the National Conference on High Blood Pressure Control in Native American Communities, U.S. Department of Health, Education, and Welfare, National Institutes of Health, NIH Publication No. 79-1960, April 1977, Reprinted 1979.

Red Horse, J. G., Lewis, R., Feit, M. *et al.*, "Family behavior of urban American Indians," *Soc. Casework*, *59*:67-72, 1978.

Samet, J. M., *et al.*, "Respiratory disease mortality in New Mexico's American Indians and Hispanics," *AJPH*, 70(5):492-7, May 1980.

Sievers, M. L., "Historical Overview of Hypertension Among American Indians and Alaskan Natives," *Arizona Medicine*, 34(9):607-610, Sept. 1977.

Vogel, V., *American Indian Medicine*, (Norman: The University of Oklahoma Press, *1970*).

REFERENCES ON
ASIAN AND PACIFIC AMERICANS

Campbell, T. and Chang, B. "Health Care of the Chinese in America," in Henderson, G. and Primeaux, M. Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 162-171.

The authors discuss stereotyping of Chinese Americans and the historical development of their immigration to the U.S. Three groups are identified: 1) those born in China and immigrated, 2) new immigrants of the past 20 years, and 3) first and second generation American born Chinese. They briefly present aspects of the Yin-Yang philogophy and its relationship to health, i.e., the necessary balance of opposing energy forces. The Yin-Yang theory is related to the hot-cold theory. Illness is treated with foods classified in these two categories and related to cause and care of illness. Practitioners of Chinese medicine will use acupuncture and/or herbs in treatment. Asian clients should therefore be encouraged to inform the western practitioner of the medications she/he has been using to avoid conflict in medications. Chinese medicine is usually given once whereas Western medication is prescribed in multiple doses--this has implications for the client who must take medications over a long period. The authors also discuss diet and nutrition and make some recommendations for nutritionists.

Chang, B., "Asian American Patient Care," in Henderson G. and Primeaux, M. Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 255-278.

The author begins by defining Asian Americans as those individuals with ancestral heritage from China, Japan, Korea, Southeast Asian, and Vietnam. Pa [illegible] ancestors from the Philippines, Samoa, and Guam. She groups traditional values and behavioral norms into six categories: 1) family, 2) "Situational orientation", 3) filial piety, 4) control of feelings, 5) inconspicuousness, 6) death and dying. She also provides a table conceptualizing four typological characteristics of Asians in America: 1) traditional Asians, 2) Asian Americans, 3) alienated Asians, 4) Americanized Asians. The implications for health care delivery relative to these four categories care that the clinician must adapt different strategies for each group, depending upon the client's needs.

Chung, H. J., "Understanding the Oriental maternity patient," Nurs. Clin. N. Amer., 12(1):67-75, March 1977.

This is an informative article concerning the needs of the Oriental client in relation to language, communication, and diet. It specifically addresses the maternity patient, the special dietary needs for the post-partum patient, as well as cultural norms regarding pregnancy and delivery. One particularly important point is the desire for female medical staff in the pregnancy, delivery, and post-partum periods.

Hart, D. V., "Bisayan Filipino and Malayan Folk Medicine," in Henderson, G. and Primeaux, M. eds., Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 148-161.

The author discusses characteristics of Bisayan Filipino and Malayan traditional medicine including shamans who diagnose and treat clients as well as specialists who treat specific types of ailments. Another aspect of traditional folk medicine is the hot-cold theory of disease, which is also present in Hispanic cultures. Wind as a cause of illness is discussed along with measures taken to prevent illness resulting from the body's absorption of excessive amounts of hot or cold air. Hot-cold foods and medicines restore balance and are classified into four categories: 1) different kinds of heat, 2) different kinds of cold, 3) bland taste, and 4) neutral foods. A causal relationship exists between the etiology of disease and the seasons of the year. The author provides some historical explanations of the development of these traditional systems. He also provides an extensive bibliography on culture and medicine for these groups.

Olness, K., "Indo-Chinese refugees: cultural aspects in working with Lao refugees," Minnesota Medicine, Dec. 1979, p. 871.

Describes a few Laotian cultural characteristics such as taboos, dietary preference and codes of behavior.

Tao-Kim-Ahi, A., "Orientals are Stoic," in Klein, N. ed., Culture, Curers and Contagion, (Novata, CA: Chandler & Sharp Pb., 1979) p. 166.

The author discusses the development of his attitudes toward medicine and his perceptions of proper behavior for the client and health professionals.

Yip, B. C., et al, Understanding the Pan Asian Client: Book II, 1980 (San Diego: Union of Pan Asian Communities, 2459 Market Street, 1980).

Written for the health care professional who provides human care services to Pan Asian clients, the booklet contains background information for clinicians, including historical, cultural, and social information about the various groups residing in San Diego county. Variations in social, cultural and historical circumstances is a prime factor in the differences between groups, and clinicians should be sensitive to these issues. Groups discussed are: the Burmese, Cambodians, Chinese, Guamanians, Japanese, Koreans, Laotians and Lao-Hmong, Philipinos, Samoans, Thais, and Vietnamese. A bibliography of further resources is provided.

Non-annotated Bibliographic Sources

Agren, H., "Patterns of tradition and modernization in comtemporary Chinese Medicine," in Kleinman *et al*, *Patients and Healers in the Context of Culture*, 1980:37-60.

Callao, M. J., "Culture shock--West, east and west again," *Personnel Guid. J.*, 51:413-416, 1973.

Campbell, T. and Chang, B. "Health Care of the Chinese American," *Nurs. Outlook* 21:249, 1973.

Caudill, W., "The cultural and interpersonal contest of everyday health and illness in Japan and America," in Leslie, C., ed., *Asian Medical Systems: A Comparative Study*, (Berkeley: Univ. California Press, 1975), p. 159-77.

Chen, J. Y., "Techniques used in acupuncture," in Risse, ed., *Modern China and Traditional Chinese Medicine*, (Springfield, IL: Charles C. Thomas, 1973) p. 56-63.

Crozier, R. C., "Traditional medicine in Modern China: Social, political and cultural aspects," in Risse, ed., *Modern China and Traditional Chinese Medicine*, (Springfield, IL: Charles C. Thomas, 1973) p. 30-48.

Day, Robert W., "Commentary on health care in the People's Republic of China: Implications for the United States," in Kleinman *et al*., (DHEW Pub. No. NIH 75-653, 1975) p. 729-732. *Medicine in Chinese Cultures*.

Dunn, F. L., "Traditional Asian medicine and cosmopolitan medicine as adaptive systems," in Leslie, C. ed., *Asian Medical Systems: A Comparative Study*, (Berkeley: Univ. California Press, 1975) p. 133-158.

"Food Composition Table for Use in East Asia," U.S. Dept. of Health Education and Welfare, Nutrition Program, Center for Disease Control, Health Services and Mental Health Administration and FAO Food Policy and Nutrition Division, December, 1972.

Friedman, E., "The Chinese Hospital: A board faces tradition and change in an old community," *Trustee* 34(8):24-27, 1981.

Gale, J. L., "Patient and practitioner attitudes toward traditional and western medicine in a contemporary Chinese setting," in Kleinman *et al*., *Medicine in Chinese Cultures*, (DHEW Pub. No. NIH 75-653, 1975) p. 195-208.

Gaw, A., "An integrated approach to the delivery of health care to a Chinese community in America: the Boston experience," in Kleinman *et al*., *Medicine in Chinese Cultures*, (DHEW Pub. No. NIH 75-653, 1975) p. 327-350.

Geiger, H. J. "Health care in the People's Republic of China: implications for the United States," in Kleinman *et al*., *Medicine in Chinese Cultures*, (DHEW Pub. No. NIH 75-653, 1975) p. 713-724.

Ghen, R., "Samoans in California," *Social Work*, March, 1973.

Kaneshige, E., "Cultural factors in group counseling and interaction," Personnel Guid. J., 51:407-412, 1973.

King, H., "Selected epidemiological aspects of major diseases and causes of death among Chinese in the U.S. and Asia," in Kleinman et al., Medicine in Chinese Cultures, (DHEW Pub. No. NIH 75-653) p. 487-550.

Kitano, H. L., Japanese Americans: The Evolution of a Subculture, 2nd ed. (Englewood Cliffs, NJ: Prentice Hall, 1976).

Kleinman, A., et al., Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies, (U.S. Department of Health, Education, and Welfare, National Institutes of Health, DHEW Pub. No. NIH 75-653, 1975, p. 512-514.

Kleinman, A. J., "Toward a comparative study of medical systems: an integrated approach to the study of relationship of medicine and wellness," Sci. Med. & Man, 1:55, 1973.

Kuo, W., "Theories of migration and mental health: an empirical testing on Chinese-Americans," Soc. Sci. & Med., 10:297-306, 1976.

Leslie, C. ed., Asian medical systems: A comparative study, (Berkeley: Univ. California Press, 1975).

Levin, K., "Medicine and Chinese society," in Risse, ed., Modern China and Traditional Chinese Medicine, (Springfield, IL: Charles C. Thomas, 1973).

Lyman, S., The Asian in the West (Reno, NE: Desert Research Institute, 1970).

Marmot, M. G. and Syme, S. L., "Acculturation and coronary heart disease in Japanese Americans," Am. J. Epidimiol., 104:225, 1976.

National Symposium on High Blood Pressure Control in U.S. Asian/Pacific Populations -- Summary Report, (U.S. Department of Health, Education, and Welfare, National Institutes of Health, DHEW Publication No. NIH 79-1609, 1979).

Okano, Y. and Spika, B., "Ethnic identity, alienation and achievement in Japanese-American families," J. Cross-cultural Psychology, 2:273, 1971.

Porkert, M., "The Theoretical Foundations of Chinese Medicine Systems of Correspondence, (Cambridge, MA: The MIT Press, 1974).

Read, D., Labarthe, D., and Stallones, R., "Health effects of westernization and migration among Chamarros," Am. J. Epidemiology, 92:94, 1970.

Risse, G., ed., Modern China and Traditional Chinese Medicine: A Symposium Held at the University of Wisconsin, Madison, (Springfield, IL: Charles C. Thomas, 1973).

Rosen, S., "Health care in modern China: An eyewitness," in Risse, ed., Modern China and Traditional Chinese Medicine, (Springfield, IL: Charles C. Thomas, 1973) p. 147-156.

Sue, S. *et al.*, "Chinese American personality and mental health," Amerasia J., 1(2), July 1971.

---- and McKinney, H. "Asian Americans in the community mental health care system," Amer. J. Orthopsychiatry, January, 1974.

---- and Sue, D. W., "Understanding Asian-Americans: the neglected minority," Personnel Guid. J., 51:387-389, 1973.

Tillotson, J. L., *et al.*, "Epidemiology of coronary heart disease and stroke in Japanese men living in Japan, Hawaii and California: methodology for comparison of diet," Amer. J. Clin. Nutri., 26:177, 1973.

Watanbe, C., "Self-expression and the Asian American experience," Personnel Guid. J., 51:390-395, 1973.

Weaver, J. L., National health policy and the underserved: Ethnic minorities, women and the elderly (St. Louis: C. V. Mosby, 1976).

Wong, J. and Banerian, J. Indochinese Cultural Awareness Training Manual (San Diego: IndoChinese Community Health and Education Project, 1979).

Yamamoto, Y., Evaluation of Pacific/Asian elderly health services, (Los Angeles County, 1979).

Yip, B. C., *et al.*, Understanding the Pan Asian Client, (San Diego: Union of Pan Asian Communities, 1978).

REFERENCES ON BLACK AMERICANS

Bloch, B., "Nursing intervention in Black patient care," in Luckraft, ed., Black Awareness: Implications for Black patient care, (New York: Amer. J. Nursing, 1976) p. 27.

Discusses physiological differences between Black and non-Black patients to which nurses should be sensitive. For example, recognizing physiological changes in the skin helps the detection of significant changes in health and often depends upon observatin of changes in skin color. Points out the importance of the client's social and psychological environment and its influence on health care. Stresses that religion can be a support for the client, especially in cases of life-threatening illnesses. Also addresses cultural characteristics, such as folk medicine and Black English, which must be considered when working with Black clients.

Elam, L. C., "What does the ghetto want from medicine," in Norman, ed., Medicine in the Ghetto, (N.Y.: Appleton-Century-Crofts, 1969) p. 33-42.

Identifies some general expectations of health care by the general public, which include high quality medical care (i.e., availability and accessibility, competence of medical staff, continuity, responsive service delivery, and individualized care). He points out how these expectations are not met for the ghetto resident and emphasizes the urgency in the health status of the ghetto and the need for change, including rapid, large scale expansion of services.

Nobles, W. W. and Nobles, G. M. "African roots in Black families: the social-psychological dynamics of Black family life and the implications for nursing care," in Luckraft, ed., Black Awareness: Implications for Black patient care, (New York: Amer. J. Nursing, 1976), p. 6.

Discusses the influence of African culture on the Black American social system. For health professionals, the authors suggest that an applied awareness of cultural differences such as dietary needs, personal hygiene, use of home remedies, religion, and other aspects of Black culture will help to provide better health care for Blacks. Illness is viewed as a family condition, and therefore responsibility for health care rests not only with the clinician and the individual but with the entire family. The relationship between an individual's illness and the extended family therefore must be taken into consideration, because it has strong implications for outpatient care and rehabilitation for the individual.

Norman, J. C., ed., Medicine in the Ghetto (New York: Appleton-Century-Crofts, 1969).

A series of articles that discuss the social, political, and economic factors of health care in the ghetto. The authors examine health care delivery in varius urban centers and the role of the ghetto physician. Suggestions for improved medical care include the need for mutual trust and tolerance between physician and client, the taming of the professional ego, and a radical change in the political atmosphere that will allow adaptation and change.

Smith, J. A., "The role of the Black clergy as allied health care professionals in working with Black patients," in Luckraft, ed., Black awareness: Implications for Black patient care, (New York: Amer. J. Nursing, 1976). p. 12.

Emphasizes the important position of Black clergy in the community and their role as liaison between health professional and client. Black clergy have an understanding of Black culture and possess academic credentials. In addition, they are often aware of the client's emotional and psychological history and also have an established working relationship with family members. Health professionals should seek their help when working with Black clients and families.

Snow, L. F., "Folk medical beliefs and their implications for the care of patients: a review based on studies among Black Americans," in Henderson, G. and Primeaus, M. Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 78.

States that a viable folk medical belief system exists within the Black community. Discusses Black folk beliefs concerning health, the causes of illness and cure, and attitudes of Blacks with respect to their world view. An ethnographic survey of Tucson, Arizona Blacks described three themes as influential in Black attitudes toward their environment. They are: 1) "that the world is a dangerous and hostile place; 2) that the individual is liable to attack from external sources; and 3) that the individual is helpless and has no internal resources to combat such an attack but must depend upon outside aid." The author also discusses the organization of folk medical beliefs around natural and unnatural phenomena of which health professionals should be aware. For example, clinicians should be aware that when clients arrive for health care they have most likely tried all avenues of folk medicine before seeking orthodox health care. Thus, the clinician should inquire as to which remedies have been tried so that there will be no incompatibility in medications. The clinician should also try to make suggestions that are compatable to the client's belief system.

_________, "Voodoo illness in the Black population," in Klein, Culture Curers and Contagion, (Novata, CA: Chandler & Sharp, 1979) p. 179-184.

Discusses the importance of examining why orthodox scientific medicine is unsatisfying to the Black patient. Stresses the need for health professionals to know about witchcraft beliefs and the symptoms that indicate that an individual has undertaken its practice. This can help prevent inaccurate diagnosing of an individual as mentally ill, giving confusing advice to the client, and treatment that does not reach the cause of the illness.

Taylor, C., "Soul talk: a key to Black cultural attitudes," in Luckraft, ed., Black awareness: implications for Black patient care, (New York: Amer. J. Nursing, 1976).

Discusses the negative attitudes toward Black English dialect and points out that such attitudes can have an impact on health care. Cautions health professionals to be sensitive to the language and cultural differences between Black and non-Black communities and to incorporate this sensitivity into the health care system.

Thomas, D. N., "Black American patient care," in Henderson, G. and Primeaux, M. eds., Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 209.

Provides socioeconomic aspects of health among the black population and discusses such sociocultural aspects as family, language, food, religion, and personal hygiene and grooming, which the health professional should be aware of in serving black clients. Also suggests some skills for interviewing black clients and discusses psychosocial issues, such as paranoia and hostility that may occur and their causes.

Washington, W., "Health education: relevance to the Black community," Urban Health, Nov. 1979:37-38.

Suggests that traditional theories of health education may not be appropriate to the Black community because of the unique historical and sociological characteristics of Blacks. Derived from heterogeneous populations, health education theories are subject to inaccuracies and invalidations when applied to Blacks. Research methods and evaluation techniques have been primarily designed by non-Black researchers and do not consider the cultural, social, and political experience of Black Americans. The author recommends that these theories should be re-evaluated in terms of the special needs of the Black population.

Non-annotated Bibliographic Sources

Banks, W. M., "The Black client and the helping professionals," in The Black Psychologist, ed. by R. Jones, (New York: Harper & Row, 1972). p. 205-211.

Blackwell, J. E., The Black Community: Diversity and Unity (New York: Dodd Mead, 1975).

Bullough, B., "Alienation in the ghetto," Amer. J. of Sociology, 72:469-78 March, 1967.

Harburg, E. et al., "Socio-ecological stress, suppressed hostility, skin color, and Black-male blood pressure--Detroit," Psychosomatic Medicine, 35(4):276-296, July-Aug. 1973.

________, "Skin color, ethnicity and blood pressure I: Detroit Blacks," AJPH, 68(12):1177-1183, Dec. 1978.

Hongladaron, G. C. and Russell, M., "An ethnic difference--lactose intolerance," Nursing Outlook, 24:764-765, 1976.

Hosten, A. O., "Hypertension in Black and other populations: envirnomental factors and approaches to management," J. Natl. Med. Assoc., 72(2):111-117, Feb. 1980.

Johnson, K. R., Ghetto Talk and What You Should Know About It, (A sound recording/audiocassette which describes the development of Black dialect and discusses the linguistic elements in the dialect. Also discusses non-verbal communication among Blacks).

Jones, R., Black Psychology, (New York: Harper & Row, 1972).

Keil, J. E., et al., "Hypertension: effects of social class and racial admixture," AJPH, 67(7):634-639.

Leobl, S., "SLE, another Black disease," NY J. Health, 4:50-51, Sept. 1973.

Luckraft, D., Black Awareness: Implications for Black patient care, (New York: Amer. J. Nursing, 1976).

Martin, P. E. and Martin, J. M., The Black extended family, (Chicago: University of Chicago Press, 1978).

Mitchell, A. C., "Black Skin: An historical, psychological and health care perspective," J. Cont. Educ. Nurs., 10(6):28-33, Nov. - Dec., 1979.

Pugh, R. W., Psychology and the Black experience, (Monterey, CA: Brooks-Cole Publishing, 1972).

Roach, L. R., "Color changes in dark skin," in Henderson, G. and Primeaux, M. eds., Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 287.

Scott, C. S., "Health and healing practices among five ethnic groups in Miami, Florida," in Henderson, G. and Primeaux, M. Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 102.

Seham, M., Blacks and American Medical Care, (Minneapolis: Univ. Minnesota Press, 1973).

Snow, L. F., "Sorcerers, saints and charlatans: Black folk healers in urban America," Culture Med. Psychiatry, 2:87-91, 1978.

_________, "Folk medical beleifs and their implications for care of patients: A review based on studies among Black Americans," Ann. Intern. Med., 81:82-96, 1974.

_________, "I was born just exactly with the gift," An interview with a Voodoo practitioner," J. Am. Folklore, 86:272-281, 1973.

________, "Popular medicne in Black neighborhoods," in Ethnic Medicine in the Southwest, Spicer, E. H. ed., (Tucson: Univ. of Arizona Press, 1977) p. 19-98.

Stokes, L., "Search for better health care in the black communty," J. Natl. Med. Assoc., 70(1):749-52, Oct. 1978.

Syme, S. L., "Social class and racial differences in blood pressure," AJPH, 64(6):619-620, 1974.

Thomas, D. C., Sociology of the Black Experience, (Westport, CT: Greenwood Press, 1974).

Walton, G., "Causes of hypertension in the Black community," Wisconsin Medical J., 74:10-11, July, 1975.

Ware, D. R., "Black health providers task force on hypertension," Urban Health, 8(5), June, 1979.

White, E. H., "Health and the Black person: an annotated bibliography," in Luckraft, Black awareness: implications for Black patient care, (New York: Amer. J. Nursing, 1976) p. 40.

Williams, P. B., "Coronary heart disease risk factors among Black Americans," Urban Health, 8(9):34-38, Nov. 1979.

Williams, R. A., "Black related diseases," J. Black Health Perspective, 1:35-40, Aug. 1970.

________, Hypertension and the Black male; a clinical and epidemiological perspective (West Point, PA: Merck Inc., 1973).

Williams, R., "The clinical and physiological assessment of Black patients," in Luckraft, ed., Black awareness: implications for Black patient care, (New York: Amer. J. Nursing, 1976) p. 16.

REFERENCES ON HISPANIC AMERICANS

Hoppe, S. K. and P. L. Heller, "Alienation, familism and the utilization of health services by Mexican-Americans," J. Health & Social Behavior, 16:304, Sept. 1975.

The authors point out the importance of distinguishing between preventive and curative aspects of health care. They found that familism negatively influenced utilization of health care with some illnesses but positively influenced pre-natal care. The more highly familistic individuals tended to seek curative measures first within the kin group according to the role responsibilities and relationships of kin group members.

Lieberman, L. S., "Medico-nutritional practices among Puerto Ricans in a small urban northeastern community in the U.S.," Soc. Sci. & Med., 13B:191-198, 1979.

The results of a survey conducted in a mainland Puerto Rican community describe the successful incorporation of hot-cold theory of medical treatment with western theories of nutritional and disease etiology, treatment, and prevention. Stresses the role of indigenous paraprofessionals as liaison between community and health institution.

Marcos, L. R., et al., "The language barrier in evaluating Spanish-American Patients," in Henderson, G. and Primeaux, M. Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981) p. 38.

Studied the effect of interview language on verbal behavior of Spanish-speaking clients and found that when speaking English they were more formal, less communicative and emotionally withdrawn. Emphasizes the importance that clinicians be sensitive to the language barrier effect and to culturally-bound attitudes and beliefs, such as "machismo," "ataque," "black magic," and spiritualism.

Martinez, R. Arguijo, Hispanic Culture and Health Care: Fact, Fiction Folklore, (St. Louis: The C. V. Mosby Co., 1978).

A collection of readings concerning Mexican-American health care and beliefs. Discusses the influences of cultural factors such as religion, language, family structure, and community on health beliefs and presents common barriers to utilization of health care.

Murillo-Rohde, I., "Hispanic American patient care," in Henderson, G. and Primeaux, M. eds., Transcultural Health Care, (Menlo Park, CA: Addison-Wesley, 1981), p. 224.

Points out the diversity of the Spanish-speaking population and the need to consider the unique characteristics of each group in terms of culture, language differences, values, and belief systems. Discusses the hot-cold theory of disease and treatment as a health system characteristic of Hispanic groups and the importance of dietary factors in prescribing regiments for treatments which related to hot-cold theories. Suggests that utilization of the hot-cold classification of foods can help reinforce medical treatment.

Nall, F. C., and Speilberg, J., "Social and cultural factors in the responses of Mexican-Americans to medical treatment," J. Health and Soc. Behavior, 8:299-308, 1967.

Research found that "milieu" rather than folk medical belief has an inhibiting effect on the acceptance of certain medical treatment, especially when hospitalization is recommended.

Trotter, R. T., and Chavira, J. A., A Curanderismo: The Gift of Healing, (Athens: Univ. Georgia Press: in press).

The author analyzed 1235 home remedies of Mexican Americans and determined patterns of illnesses that he grouped into a list of 70 of the most common. Tables representing these diseases are included as well as a breakdown as to which are more common for each sex.

Welch, S. J. and M. Steinman, "Some social and attitudinal correlates of health care among Mexican Americans," J. Health and Soc. Behavior, 14:204-13, 1973.

Their survey of Mexican American communities showed that underutilization of health care facilities was due to income level, age, education and distrust of doctors (based on their previous experience with medical staff). These findings refute much of the literature that indicates that cultural reasons are major factors in attitude and underutilization of health care.

Non-annotated Bibliographic Sources

Abril, I., "Mexican-American folk beliefs: how they affect health care," Amer. J. Matern. Child Nursing, (May/June, 1977:168-173).

Acuna, R, Cultures in Conflict: Problems of the Mexican Americans (New York: Charter School Books, 1970).

Anderson, R., et al., "Access to medical care among the Hispanic population of the south-western United States," J. Health Soc. Behavior 22:78-89, March, 1981.

Bailey, M. A., "Nutrition education and the Spanish-speaking American," J. Nutrition Educ. 2:50-54, Fall 1970.

Bobbitt, R. A., et al., "A Chicano version of the Sickness Impact Profile (SIP)," Culture, Medicine, and Psychiatry 4:137-150, 1980.

Cervantes, R. A., "The failure of comprehensive health care services to serve the urban Chicano," Health Services Report, 87:932-940, 1972.

Clark, M. Health in the Mexican-American Culture: A Community Study, (Berkeley: Univ. California Press, 1970).

Cordaso, F. and Bucchioni, E., eds. The Puerto Rican Experience: A Sociological Sourcebook (New Jersey: Littlefield Adams, 1973).

Currier, R. L., "The hot-cold syndrome and symbolic balance in Mexican and Spanish-American folk medicine," in Martinez, ed., Hispanic Culture and Health Care: Fact, Fiction, Folklore, (St. Louis: The C. V. Mosby Co, 1978) p. 138-151.

Del Castillo, J. C., "The influence of language upon symptomatology in foreign born patients," Amer. J. Psychiat., 127(2):160-162, Aug. 1970.

Dorsey, P. R., and Jackson, H. Q., "Cultural health traditions: The Latino/Chicano perspective," in Providing Safe Nusring Care for Ethnic People of Color ed. by Branch, M. F. and Paxton, P. P. (New York: Appleton-Century-Crofts, 1976), p. 41-79.

Edgerton, R. B., Karno, M. and Fernandez, I., "Curanderismo in the metropolis," Amer. J. Psychiatry 24:124-134, 1970.

Elizonda, N. C., "Hypertension screening and education of a Mexican American/Chicano population," (Wichita, Kansas: Univ. Kansas School of Medicine-Wichita, Division of Health Care Outreach, n.d.).

Fabrega, H. Jr., and Roberts, R. E., "Ethnic differences in the outpatients use of a public charity hospital," AJPH, July, 1972, p. 936-941.

Falk, V., "Planning Health Education for a Minority Group: The Mexican-Americans," Inter. J. Health Education, 22(2):113-121, April-June, 1979.

First Conference on Hypertension Among Puerto Ricans--Summary Report, (U.S. Department of Health, Education, and Welfare, National Institutes of Health, NIH Publication No. 80-1962, April 1980.)

Fitzpatrick, J., Puerto Rican Americans: The Meaning of migration to the mainland, (Tucson: Viking Fund Pbs. in Anthropology, No. 50, Univ. Arizona Press, 1971).

Gaviria, M. and G. Stern, "Problems in designing and implementing culturally relevant mental health services for Latinos in the U.S.," Soc. Sci. & Med., 14B:65-71, 1980.

Hautman, M., "Folk health and illness beliefs," Nurse Practitioner, 4:23-26, July/August, 1979.

Hanson, R., C., and Beech, M. J. "Communicating health arguments across cultures," in Martinex, ed., Hispanic Culture and Health Care: Fact, Fiction, Folklore, 1978:226-236. (St. Louis: The C. V. Mosby Co., 1978) p. 226-236.

Harwood, A., "The Hot-Cold theory of disease: implications for treatment of Puerto Rican patients," JAMA, 216:1153, 1971.

Johnson, C., "Nursing and Mexican-American Folk Medicine," Nurs. Forum, 3:104-113, 1964.

Kay, M. A., "Health and illness in a Mexican American barrio," in Ed. H. Spicer, ed., Ethnic Medicine in the Southwest, (Tucson: The Univ. of Arizona Press, 1977) p. 99-168.

Kiev, A., Curanderismo: Mexican-American Folk Psychiatry, (New York: Free Press, 1968).

Lin, T. Y. et al., "Ethnicity and patterns of help-seeking," Culture, Medicine and Psychiatry, 2:3-14, 1978.

Litman, T. J., "The family as a basic unit in health and medical care: A sociobehavioral overview," Soc. Sci. & Med., 8:495-519, 1974.

Lubchansky, I., G. Egri, and Stokes, J. "Puerto Rican spiritualists view mental illness: the faith healer as paraprofessional," Amer. J. Psychiat., 127(3):312, Sept. 1970.

Martinez, C. and Martin, H. W. "Folk diseases among urban Mexican Americans: etiology, symptoms, and treatment," JAMA, 196(2):161, April 11, 1966.

Meyer, G. G., "Folk medicine in the Southwest," Texas Medicine, 71:96 Feb. 1975.

Milo, N., "Values, social class, and community health services," Nurs. Res. 16:26-31, Winter, 1967.

Montoya, M., "Heart disease in the southwest: a residential and ethnic overview," Presented at the Annual Meeting of the American Public Health Assoc., Los Angeles, California, 1978.

Murillo, N., "The Mexican American Family," in Hispanic Culture and Health Care: Fact, Fiction, Folklore, Richardo A. Martinez, ed., (St. Louis: The C. V. Mosby Co., 1978) p. 3-18.

Quesada, G. M., "Language and communication barriers for health delivery to a minority group," Social. Sci. & Med., 10:323-327, 1976.

Quesada, G. M. and Heller, P. L. "Sociocultural barriers to medical care among Mexican American in Texas: A summary report of research conducted by the Southwest Medical Sociology Ad Hoc Committee," Medical Care 15:93-101, May (Supplement) 1977.

Ramirez, A. and Lasater, T. M., "Ethnicity of communicator, self-esteem and reactions to fear-arousing communications," *J. Social Psycho.*, 102:79-91, First Half, June 1977.

Rocah, M., "Mexican folk medicine: the people's health perspective," *Imprint Anthropologist* 62:795-811, October 1960.

Rubel, A., "Concepts of disease in Mexican-American Culture," *Am. Anthropologist* 62:795-814, 1960.

Samet, J. M., Key, C. R., Kutvirt, D. M., Wiggins, C. L., "Respiratory disease mortality in New Mexico's American Indians and Hispanics," *AJPH*, 70(5):492-7, May 1980.

Samora, J., "Conceptions of health and disease among Spanish-Americans," in Martinez, *Hispanic Culture and Health Care: Fact, Fiction, Folklore*, (St. Louis: The C. V. Mosby Co., 1978) p. 65-74.

Saunders, L., *Cultural Differences and Medical Care*, (New York: Russell Sage Foundation, 1954).

Tamez, E., "Curanderismo: Folk Mexican American Health Care System," *J. Psych. Nurs. Mental Health Services*, 16:34-39, Dec. 1978.

University of Texas Health Science Center at Houston, *Health Education and the Mexican American* (preliminary draft), (Houston: May, 1977).

Urdaneta, M. L., "Curanderismo and the Mexican-American client in the health care system," (Austin, Texas: The Univ. of Texas School of Nursing--Continuing Education Program, March 17-18, 1977).

Valle, R. and Vega, W. eds., *Hispanic Natural Support Systems: Mental Health Promotion Perspectives*, (California Dept. of Mental Health, 1980).

Weaver, J. L., "Mexican-American health care behavior: a critical review of the literature," *Soc. Sci. Quart.*, 54:85-102, 1972.

MIGRANT WORKERS

Anderson, W. W. and Kane, R. L., "Patterns of care given migrant workers in Utah by private physicians and clinics," *Public Health Reports*, 92:326-31, July/August, 1977.

Artschwager, K. M., "Health and illness in a Mexican-American Barrio," in *Ethnic Medicine of the Southwest*, E. Spicer, ed., (Tucson: University of Arizona Press, 1977).

Bleiweis, P. R., *et al.*, "Health care characteristics of migrant argricultural workers in three Northern Florida counties," *J. Community Health*, 3:32-43, Fall 1977.

Burine, J., ed., *Texas Rural Health Journal -- Community Assessment Issue*, (Austin, Texas: Texas Rural Health Field Services Program, December, 1980).

Clark, M., *Health in the Mexican-American Culture* (Berkeley: Univ. of California Press, 1970).

Good Neighbor Commission of Texas, *Texas Migrant Labor: A Special Report*, (Austin, Texas, 1977).

Hawkins, D. R. Jr., "Farmworker Health: Issues and Perspectives," *Nursing Dimensions* 7:15-20, Fall 1979.

Murillo-Rohde, I., "Implementing quality health care for Ethnic people of color. Cultural Sensitivity in the care of thie Hispanic patient. Part 5," *Washington State J. Nurs.* Special Supplement (1979):25-32.

Shenkin, B. N., *Health care for Migrant Workers: Policies and Politics*, (Cambridge, MA: Ballinger Publishing Co., 1974).

Slesinger, D., *Health Needs of Migrants Workers in Wisconsin*, (Madison, Wisconsin: Univ. of Wisconsin--Extension, 1979).

Solis, F., "A clinic for Mexican-American farm workers," *Amer. Lung Assoc. Bull.*, 59:9-11, Nov. 1973.

York, P. A. and Barnett, S. E., "Bilingual/Bicultural health education for children of migrant farmworkers," *Health Education*, 8:4-6, Sept./Oct. 1977.

Wingert, W. A. and Halfman, L. P. "Migrant Health Question ... United States," *Pediatric Nurs.*, November/December, 1979:19-20.

References for Improving Reader Comprehension for Clients with Low Literacy Skills

The following list includes annotated and non-annotated bibliographic sources that provide recommendations to practitioners who work with clients who have a low level of literacy, are not literate in English, or are pre-literate.

Abel, S. R. and Blackstone, M. "Color-Keyed patient medication counseling system." Amer. J. Hosp. Pharmacy, 38:704, May 1981.

> For the visually impaired client, Abel and Blackstone have developed a color-keyed system for medication counseling to help the client distinguish between different medications and to read the prescribed doses. Four separate medication calendars indicating the time of day and for which purpose each medication is prescribed are used. Large letters enable easier visual perception so that prescriptions can be read at distances of 14 and 7 inches for patients with 20/200 vision and with 20/400 vision. For their purposes, English and Spanish were used but any written language can be used. An adhesive colored dot is placed on the medication container as well as on the calendar indicating the time of day the medication is to be taken.

Boyce, M. R. "Guidelines for printed materials for older adults." From Michigan Health Council, 1407 S. Harrison Rd., Suite 340, East Lansing, MI 48823, 1982.

> Four-page folder developed by Michigan Health Council Health Promotion Project to improve the printing of materials for older adults. Includes specific suggestions for typing, photocopying, printing, language use, as well as a bibliography and names of "helpful persons."

Chatham, M. A. H., and Knapp, B. L. "Teaching patients with low literacy skills." in Patient Education Handbook (Bowie, MD: Robert J. Brady, Co., 1982), pp. 145-150.

> This chapter provides a summary of the problems for patient education posed by illiteracy and a comparison of teaching strategies based on literacy.

Doak, L. G., and Doak, C. C. "Patient comprehension profiles: recent finding and strategies." Patient Counseling and Health Education, third quarter, 1980, p. 101-106.

> Report of a Public Health Service Patient Comprehension Assessment study. Paper includes practical suggestions for practitioners who wish to lower barriers to their client's comprehension of information. Advocates the use of the WRAT word recognition test for screening patient's reading level. The test requires 2-3 minutes to administer and score.

Liberman, P., and Swartz, A. J. "Prescription dispensing to the problem patient." Amer. J. Hosp. Pharmacy. 29:163, Feb. 1972.

> Discusses some problems of the non-English speaking, semi-literate, or illiterate outpatient who is responsible for taking medication.

Typewritten directions in English are ineffective. They recommend the practice of writing directions in the client's language and suggest the availability of language guides that translate prescriptions (see Strauss, non-annotated bibliography). For Native American clients who speak unwritten languages, a pictorial label scheme is available. For those clients who have difficulty using their medication properly, the help of a neighbor or friend is recommended. Offers suggestions for improving the motivation of clients' usage of medication, such as stating clearly on the label for what purpose the drug is to be used, the importance of taking the drug regularly, translation of medical terminology into lay English, and discouraging use of vague terms. Also suggests giving the client supplemental directions to help her/him better understand the use and purpose of the medication.

Meisel, S., and Keily, K. "Graphic prescription labels." Amer. J. of Hosp. Pharmacy. 38:1116, Aug. 1981.

For non-English speaking clients, Meisel and Keily have developed graphic prescription labels that are used in conjunction with a standard prescription label. Members of the family are represented by drawing of an infant, child, adult female and male, and elderly female and male. The sun represents the time of day and moon for night. The position of the sun indicates morning, noon, and evening. The member of the family for whom the medication is prescribed is circled as well as the time of day it is to be taken. This system was found to work best with oral and/or solid medication with a regimented schedule and not as well with oral liquid, opthamalic, otic, or rectal preparations.

Mohammed, M. "Patients understanding of written health information. Nurs. Research 13:100-108, 1964.

Some of the national clearinghouse offer pretesting services or issues catalogs of materials graded for reading levels (cancer, hypertension, diabetes).

Ow-wing, S. D., and Kerner, J. A. "Color-coded prescription labelling." Amer. J. Hosp. Pharmacy. 38:631, May 1981.

For the illiterate, Ow-wing and Kerner have developed a system of color-coded prescription labelling that helps the client to take responsibility for her/his own medication. Each medication is identified by a colored adhesive dot placed horizontally on the medication bottle. Each dot represents the frequency each dose is to be taken. For liquid medication, a medicine cup is marked for the level of medication to be taken with dots on the medication bottle to indicate the number of times a day it should be taken.

"References and Abstracts: Teaching Adult Patients with Low Literacy Skills" from Patient Learning Associates, Inc., 4 Chilham Ct., Potomac, MD 20854, (301) 340-9894. Feb. 19, 1981.

Abstracts of 14 articles or books that relate to the teaching of patients with low literacy skills.

Non-Annotated Bibliographic Sources

Becker, M. H., and Maiman, L. A. "Strategies for enhancing patient compliance." J. Community Health. 6(2):113, Winter 1980.

Freimuth, V. S. "Assessing the readability of health education messages." Public Health Report. 94(6):568-70, Nov./Dec. 1979.

Gasek, J. "Community with the communicatively impaired person." J. Canadian Dietetics Assoc. 40(2):99-103, Apr. 1979.

Hardie, N. R., Gagon, J. P., and Eckel, F. M. "Feasibility of symbolic directions of prescription labels." Drug Intel. Clin. Pharmacy. 13:588, Oct. 1979.

Hittleman, D. R. "Readability, readability formulas, and Cloze: selecting instructional materials." J. Reading. 22(2), Nov. 1978.

Katzoff, J. "Breaking the language barrier with E.D.P." Amer. J. Hosp. Pharmacy. 26:698, Dec. 1969.

Montgomery, T. A. "Health care for the underprivileged in the land of affluence: California Native Americans." Pediatrics. 62(3):377, 1978.

Morris, L. A. "Application of the readability concept." Amer. J. Hosp. Pharmacy. 37(11):1504-09, Nov. 1980.

Ontog, J. P. "Matching readability to educational level." (abstract) Amer. J. Nursing. 78(11):1907, Nov. 1978.

Spadaro, D. C., et al. "Assessing readability of patient information materials." Amer. J. Hosp. Pharmacy. 37(2):215-21, Feb. 1980.

Strauss, S., and Blumberg, M. "A multi-lingual guide for pharmacists." Pharm. Times. 36:50-52, Aug. 1970.

Vivian, A. S., et al. "Readability of patient education materials." Clin. Therapeutics. 3(2):129-136, 1980.

---. "A multi-lingual guide for pharmacists." Pharm. Times. 36:54-63, Sept. 1970.

---. "Nutrition education geared to patients who have had minimal schooling." Hospitals, J.A.H.A. 51:14-15, July 1, 1977.

Bibliographic Sources on the Hearing Impaired

Becker, G., "Coping with stigma: lifelong adaptation of deaf people," Soc. Sci. Med. (Med. Anthropol) 15B(1):21-4, Jan. 1981.

Benson, E. R., "Health Promotion for the Elderly," Nurs. Clinics N. America. 14:577, Dec. 1979.

Blackstrom, B., "Educational remarks on rehabilitation of the hard-of-hearing," Scand. Audiol., (Suppl.), 8:134-7, 1978.

Bowling, B., Effective Patient Education Techniques for Use with the Aging Patient, (Lexington, KY: Univ. of Kentucky, Center for Learning Resources, College of Allied Professions and the Multidisciplinary Center of Gerontology, Administration on Aging, Grant No. 90-AT-2097/01, 1981).

Bradford, L. J. and Hardy, W. G. Hearing and Hearing Impairment, (New York: Grune & Stratton, 1979).

Bradley, G., "Understanding hearing loss," J. Pract. Nurs., 30(5):27-29, May 1980.

Brenny, A., "A hearing conservation program: general considerations for the occupational health nurse," Occup. Health Nurse (NY), 27(12):16-20, Dec. 1979.

Cary, R., "Patients who cannot hear," Nursing Forum, 3(11):291-299, 1972.

De l'Aune, W., "Hearing: its evolution and ways of compensating for its loss," J. Visual Impair. and Blindness, 74(1):14-23, Jan. 1980.

De Pietro, L., Deaf Patients: Special Needs, Special Responses. A Handbook for Health Care Professionals. Washington, DC: 1979. The National Academy of Gallaudet College.

Dinsmore, P. A., "A health education program for elderly residents in the community." Nurs. Clinics for N. Amer., 14:585, Dec. 1979.

Dye, B., "Hearing conservation education program," Occup. Health Nurs. (NY), 27(1):12-14, Jan. 1979.

Epstein, R. and L. Manson, "First questions on the HEW handicap regulations," Hospitals, JAHA, 51:57-60, Oct. 1977.

Farrugia D. and Austin, G. F., "A study of social-emotional adjustment patterns of hearing-impaired students in different educational settings," Am. Ann. Deaf, 125(5):535-41, Aug. 1980.

Galbraith, G. et al., "Interfacing an inexpensive home computer to the videodisk: educational applications for the hearing impaired," Am. Ann. Deaf, 124(5):534-41, Sept. 1979.

Golden, P. and M. Ulrich, "Deaf patients' access to care depends on staff communication," Hospitals, JAHA, 52:86-90, May 1978.

Hicks, W., "Communication variables associated with hearing impaired/vision impaired persons -- a pilot study," Am. Ann. Deaf, 124(4):419-22, Aug. 1979.

Issacs, M., et al., "Patterns of drinking among the deaf," Am. J. Drug Alcohol Abuse, 6(4):463-76, 1979.

Kane, D., Sr., "Communication with the deaf patient in the operating room," Assoc. Oper. Room Nurses, 5:58-63, May 1968.

Kennedy, E., "Pedagogical and social rehabilitation of the hard-of-hearing," Scand. Audiol (Suppl.), 8:138-40, (Supplement) 1978.

La Gow, R. et al., "Design and development of a basic reading program for the hearing impaired," Am. Ann. Deaf, 124(5):635-31, Sept. 1979.

Laursen, E., "Pedagogical and social rehabilitation of the hard-of-hearing," Scand. Audiol., 8:138-40, Supplement 1978.

Leutenegger, R., Patient care and rehabilitation of communication-impaired adults, (Springfield, IL: Thomas, 1975).

Lloyd, G. T. and Curry, D. E., "Meeting the deaf and hospitalized person's communication needs," The Deaf American, October, 1979, p. 7-8.

Maclean, G., and Becker, S., "Studies of the psychosocial adjustment of the hearing-impaired: I. Adolescents and their families, A pilot study," Can. J. Psychiatry, 24(8):744-8, Dec. 1979.

Madell, J. R., "The hard of hearing patient--special considerations for nursing care," J. Pract. Nurs., 23:22-24, Dec. 1973.

Obstacles: Special Committee on the Disabled and the Handicapped. First Session, Thirty-Second Parliament, 1980-81, the Third Report. (Minister of Supply and Services, Canada, 1981, Cat. number XC 2-321/5-03E).

Quarrington, B., "Psychosocial adjustment of the deaf." Can. J. Psychiatry, 25(4):350-3, June 1980.

Rapin, I., "Effects of early blindness and deafness on cognition," Res. Publ. Assoc. Res. Nerv. Ment. Dis., 1979:189-245.

Rosen, J., "Psychological and social aspects of the evaluation of acquired hearing impairment," Audiology, 4(2):95-98, April 1979.

Rosenthall, R., The Hearing Loss Handbook, (New York: St. Martin's Press, 1975).

Ross, M., Principles of Aural Rehabilitation, (Indianapolis: Bobbs-Merrill, 1972).

Senty, C. D., "Communicating with the Deaf Patient," The Deaf American, p. 21, Mar. 1967.

Shulman, J., et al., "Multi-level captioning: a system for preparing reading materials for the hearing impaired," Am. Ann. Deaf, 124(5):559-67, Sept. 1979.

"Visual Impairment," Med. Times, 107(9):188-192, Sept. 1979.

Watson, P., "The utilization of the computer with the hearing impaired and the handicapped," Am. Ann. Deaf, 124(5):670-80, Sept. 1979.

Weinberger, M., "Social and psychological consequences of legitimating a hearing impairment," Soc. Sci. Med. (Med. Psychol. Med. Sociol), 14B(3):213-22, May 1980.

"What if your patient is also deaf?" R.N. Magazine. June 1976. Reproduction available from Public Service Programs, Gallaudet College. See resource section for address.

Wright, M., "Education: The key to preventing hearing loss," Occup. Health Saf., 49(1):38-41, Jan. 1980.

Bibliographic Sources on the Sight Impaired

Acton, J. J., "Educating the blind diabetic about his condition," *J. Visual Impair. and Blindness*, 72(9):366-7, Nov. 1978.

Barron, S., "Blindness and diabetes from a psychologist's perspective," *J. Visual Impair. and Blindness*, 72(9):354-7, Nov. 1978.

Bowling, B., *Effective Patient Education Techniques for Use with the Aging Patient*, (Lexington, KY: Univ. of Kentucky, Center for Learning Resources, College of Allied Health Professions and the Multidisciplinary Center of Gerontology, Administration on Aging, Grant No. 90-AT-2097/01, 1981).

Boyles, V. A., "Injection aids for blind diabetic patients," *Amer. J. Nursing* 77(9):1456-8, Sept. 1977.

Caplan, L., "Pre-education of the potially blind as a deterrent to suicide," *Psychosomatics*, 22(2):165-169, Feb. 1981.

De Pauw, K. P., "Physical education for the visually impaired: a review of the literature," *J. Visual Impair. and Blindness*, 75(4):162-164, May 1981.

Fulton, M., *et al.*, "Helping diabetics adapt to failing vision," *Amer. J. Nurs.*, 74(1):54-57, Jan. 1974.

Hall, A., "Recommendations for evaluating innovative products for the visually handicapped," *J. Visual Impair. and Blindness*, 74(3):89-92, March 1980.

Kelleher, D. K., "Orientation to low vision aids," *J. Visual Impair. and Blindness*, 73(5):161-166, May 1979.

Kirchner, C. and Peterson, R. "Ethnicity and rehabilitation: an analysis of blind and vidually impaired clients in the federal/state VR systems," *J. Visual Impair. and Blindness*, 75(4):197-189, April 1981.

Kolterman, S., "Practical techniques for instructing the visually impaired diabetic," *J. Visual Impair. and Blindness*, 72(9):368-721, Nov. 1978.

Kupfer, C., "Evaluation of the treatment of diabetic retinopathy: A research project," *The Sight Saving Review*, 43(1):17-28, Spring 1973.

Lambert, R. M., West, M. and Carlin, K. "Psychology of adjustment to visual deficiences: a conceptual model," *J. Visual Impair. and Blindness*, 75(5):193-196, May 1981.

Lehon, L. H., "Development of lighting standards for the visually impaired," *J. Visual Impair. and Blindness*, 74(7):249-253, Sept. 1980.

Obstacles: Special Committee on the Disabled and the Handicapped. First Session, Thirty-second Parliament, 1980-81, The Third Report. (Minister of Supply and Services, Canada, 1981, Cat. Number XC 2-321/5-03E).

Oehler-Giarrantana, J., "Coping with diabetic retinopathy," Sundial 3(4):4-5, Dec. 1977.

________, "Meeting the psychosocial and rehabilitative needs of the visually impaired diabetic," J. Visual Impair. and Blindness, 72(9):358-361, Nov. 1978.

Pais, A., "Individualized planning and the team approach in the rehabilitation of the blind diabetic," J. Visual Impair. and Blindness, 72(9):372-378, Nov. 1978.

Primrose, M., "Orientation and mobility training for deaf-blind adults," J. Visual Impair. and Blindness, 75(3):147, March 1981.

Schultz, J., "What the health professional must know about the blind diabetic," J. Visual Impair. and Blindness, 72(9):376-8, Nov. 1978.

Schultz, J. M., and Williams, M. "Encouragement breeds independence in the blind diabetic," Nursing, 76:19-20, Dec. 1976.

Silver, F. A., "Vocational rehabilitation for the visually impaired diabetic," J. Visual Impair. and Blindness, 72(9):374-5, Nov. 1978.

Sloan, L. L., Reading Aids for the Partially Sighted: A Systematic Classification and Procedure for Prescribing, (Baltimore: Williams & Wilkins, 1977).

Sykes, K. C., "Pring reading for a visually handicapped child," Education of the Visually Handicapped, III(4):97-105, Dec. 1971.

Williams, M., "Guidelines for future service to blind diabetics: special program features," J. Visual Impair. and Blindness, 72(9):379-82, Nov. 1978.

________, "Programs for blind diabetic clients at a rehabilitation center," The New Outlook, 402-5, November 1975.

Winter, M., "Job opportunities for the visually impaired--A self-help concept," J. Visual Impair. and Blindness, 74(6):232-237, June 1980.

Zaharias, A. E., "CAPD for the blind," Nephrol. Nurse, 3(2):53-4, March-April 1981.

SELECTED AGENCIES PROVIDING HEALTH EDUCATION AND RESOURCE MATERIALS FOR THE CLIENT AND PRACTITIONER

Agencies that Serve Cultural Minorities

The agencies listed below provide patient education materials for the American Indians, Asian Americans, Black Americans, and Hispanic Americans. In particular, the materials consist of patient education handouts for the client as well as information for the health professional in the areas of transcultural education. This is a sampling of agencies and materials rather than an exhaustive presentation. Wherever possible, we have indicated whether materials are available free of charge or have indicated the price.

Action for South East Asians, Inc.,
3520 Prospect St. NW
Wasington, DD 20007

Publication:
Cultural aspects of the medical and psychiatric care of Indochinese refugees, $7.50.

Arthritis Foundation
475 Riverside Drive
New York, NY 10027

Publication:
Bibliography of recommended and not recommended public education materials. No charge. Available from the local affiliate representative.

Arthritis Information Clearinghouse
P.O. Box 34427
Bethesda, MD 20034
301-881-9411

Identifies materials concerned with arthritis and related musculoskeletal diseases and serves as an information exchange for individuals and organizations involved in public, professional and patient education. Refers personal requests from patients to the Arthritis Foundation. Also screens, collects and organizes information on arthritic conditions from various sources such as books, journals, pamphlets, bibliographies, catalogs, newsletters, bulletins, films, slide presentations, videotapes, cassettes, and other AV materials, posters, exhibits, displays; descriptions of community demonstration projects which can be adapted to arthritis; names of individuals or organizations that would be potential sources or uses of information. Distributes the Arthritis Information

Clearinghouse Bulletin, which is a communication link in the exchange of informatin between the clearinghouse, its users, and the producers of education materials. Health professionals or agencies can request to be put on the Clearinghouse mailing list to receive the Bulletin and other announcements. They can also order copies of Clearinghouse bibliographies, directories and fact sheets announced in the Bulletin. However, the Clearinghouse cannot provide actual copies of journal articles, pamphlets, or books. This service is available to health professionals, but not for the client population.

Publication: Arthritis Information Clearinghouse Catalog, 1979 (Lists materials from their computerized data base which are produced from the various agencies and organizatins related to Arthritis.)

Center for Applied Linguistics
3520 Prospect St., N.W.
Washington, DC 20007

Provides the following booklets:

Perspectives on a Cross-Cultural Problem--Getting to Know the Vietnamese
Refugee Education Guides--Glimpses of Hmong History and Culture
Background Information on the Ethnic Chinese Refugees
A Guide To Orientation Materials for Indochiese Refugees and their Sponsors--A Selected Annotated Bibliography

IndoChinese Cultural and Service Center
3030 S.W. Second Ave.
Portland, OR 97201
503-241-9393

A health education center providing culturally adapted materials and training in a broad range of health related areas for the Indo-Chinese population (including Cambodian, Laotian and Vietnamese). As a multi-service center they provide translations of health materials upon request in the three languages. They also have established a program of mental health treatment by ethnic staff. Another program they have developed concerns women's health issues including a curriculum for teaching basic health education to heads of households.

The following materials are available upon request:

Medical Guide and Glossary in Cambodian, English, Laotian and Vietamese languages). Includes basic medical terminology and health issues. Pamphlets addressing the following issues: family planning, Tuberculosis, dental care, child care and immunization."

A Curriculum Guide Teaching Refugee Women provides teaching methods and materials for developing a program for the education of refugee women in the areas of clothing, food, telephone use, home care maintenance and safety, health, transportation and places, directions and signs, numbers and money, time and weather, courtesy expressions and customs, and literacy.

The following materials are available for the client in Cambodian, Laotian and Vietnamese:
"How Pregnancy Happens, How to Prevent Pregnancy"
"Straight Talk About T.B."
"How To Examine Your Breasts"
"Postpartum Care"
"Some Questions and Answers About V.D."
"Child Health Record"
"What Is Infectious Hepatitis?"
"When Baby Is Ill"

Consumer Health Information Program and Services (CHIPS)
150 East 216th Street
Carson, CA 90745
(213)-830-0909

A bilingual consumer health information and referral service. Provides current factual health information available through the library in languages and formats easily understood by the public. A distinguishing feature is the inter-library cooperation between two regional libraries. Some of their primary activities include: for the hospital, the development of a patient information collection; for the public library, the development of a consumer health information collection; cooperation with local, state and national health organizations; daily operation in the public library of the HEALTH INFORMATION LINE (a Tel-Med system of pre-recorded health tapes by phone in both Spanish and English); acquisition and dissemination of bilingual health-related materials; a health reference service offered Statewide, and sharing of the Project's findings and specially produced health materials with other libraries, library systems, health professionals, national, state and local health organizations and the general public.

Provides the following bibliographies in health education areas:
A Selected Bibliography of Diet, Nutrition and Diet Therapy
A Selected Bibliography on Cancer
A Selected Bibliography on Prenatal, Postnatal and Infant Care
A Selected Bibliography on Allergy
A Selected Bibliography on Women's Health Care
A Selected Bibliography on Death and Dying

CHIPS also publishes a newsletter to which individuals and agencies may subscribe.

Concept Media
P.O. Box 19542
Irvine, CA 92714

Cultural Diversity and Nursing Practice, 1979. A 35mm. filmstrip and tape series including an instructors manual which discusses how awareness of the patients' cultural characteristics can help improve health care for culturally diverse groups. Written for the health professional who has contact with diverse cultural groups, this series can help professionals adapt and integrate the patients' values and beliefs into health care.

Groups discussed are Mexican-Americans of the Southwest, inner-city Blacks, Asian-Pacifics and Navajo Indians.

Cooperative Extension Service
U.S. Dept. of Agriculture
The University of Arizona
Tucson, AZ 85721

Heart-Healthy Recipes--six recipe brochures providing modified Mexican dishes which are considered "heart-healthy" and retaining the taste appeal. Brochures are available in both English and Spanish. 1976.

Lutheran Immigration and Refugee Services
Lutheran Council in the U.S.A.
360 Park Avenue South
New York, NY 10010

Provides the following bilingual brochures for Asian immigrants:
"An Orientation brochure for Cambodian Refugees Resettling in the U.S."
"An Orientation Brochure for Laotian and other Ethnic Refugees from Laos Coming to the United States Under Sponsorship of Lutheran Congregations"
"An Orientation Brochure for Vietnamese Refugees Resettling in the U.S. Through Lutheran Congregational Sponsors."
"History and Culture of Vietnam. An Introduction: A Brief Glimpse at Vietnamese History"
"The Hmong: Their History and Culture"
"An Introduction to Various Ethnic Groups from Laos"
"Laos The Land and the People"

Minnesota Department of Health
Refugee Education Resource Center
Suie 340-S Griggs Midway Building
1821 University Avenue
St. Paul, MN 55104
800-652-9747 or (612) 297-3845

Provides Indochinese Health Education Materials. A Directory of health education materials for Southeast Asian refugees, refugee sponsors and refugee health providers.

Missoula County Health Department
301 West Adler
Missoula, MT 59801
(406-721-5700)

Provides a bilingual Basic Health Care Manual in Laotian and English. The manual includes information on the following topics: basic anatomy, nutrition, birth control, immunization, communicable diseases, dental hygiene, pre- and postnatal care, first aid and over-the-counter drugs, self care and utilization of the health care system. The charge is $1.00 for each copy.

National Clearinghouse for Bilingual Education
1300 Wilson Boulevard, Suite B2-11
Rosslyn, VA 22209
703-522-0710/800-336-4560

Provides information as to names and addresses of agencies and organizations concerned with bilingual curriculum development and educational programs. One publication they produce is the Guide to Resource Organizations for Minority Language Groups which lists by ethnic group names and addresses and publications they produce.

National Clearinghouse for Mental Health Information
5600 Fisher Lane Rm. 11A-21
Rockville, MD 20847
301-443-4513

National Diabetes Information Clearinghouse
Department of Health and Human Services
Public Health Service
National Institutes of Health
Box NDIC
Bethesda, MD 2020
(301/496-7433, 202-842-7630)

Publications:
Spanish Language Materials for People With Diabetes. Selected Annotations (NIH Pub. No. 81-2180, June)
Materials and Aids for the Visually Impaired Diabetic. Selected Annotations
Behavioral and Psychosocial Issues in Diabetes: Proceedings of the National Conference
State and Federal Assistance: Resource Directory For People With Diabetes (NIH Publication No. 81-2158, May, 1981).

National Health Information Clearinghouse
P.O. Box 1133
Washington, DC 20013
800/336-4797

Acts as a health information referral agency serving both the public and health professionals. Provides information about groups and organizations concerned with health education for the public. Has an in-house data-base containing entries on health-related organizations and programs throughout the country. An inquiry and referral system allows staff to refer inquiries to the most appropriate resource and allows the resource to respond directly to the inquirer. A toll-free telephone line provides case access to the clearinghouse.

best copy available

Publications:
"Call for Health Information" (a poster)
"Health Risk Appraisals: An Inventory"
"Taking action for fitness: A Guide to Selected Information Resources"

National High Blood Pressure Education Program
National Heart, Lung & Blood Institute
Department of Health and Human Services
National Institutes of Health
120/80 National Institutes of Health
Bethesda, MD 20205

Publications:
"Behavioral and Psychosocial Issues in Diabetes: Proceedings of the National Conference"
"California Conference on High Blood Pressure Control in the Spanish-Speaking Community"
"Handbook for Improving High Blood Pressure Control in the Community"
"High Blood Pressure Control in the Work Setting: Issues, Models, Resources"
"Audio Visual Aids for High Blood Pressure Education"
"Educational Materials for Hypertensive Patients. A Catalog of Evaluated Publications"
"Directory of Community High Blood Pressure Control Activities, 2nd Ed., 1977"
"The 1980 Report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure"
"For the Client With High Blood Pressure"
"Questions About Weight, Salt, and High Blood Pressure"
"Blacks and High Blood Pressure"
"If You're Black, here are some facts you should know about high blood pressure"
"What you Should Know About The National Program to Control High Blood Pressure"
"High Blood Pressure: What You Can Do About It"
"Verdad Y Ficcion Sobre La Presion Arterial Alta"
"Alta presion de la sangre lo que usted y su familia deben saber"
"La presion arterial alta es un problema serio"
"Protect yourself against the silent killer--high blood pressure"
"Patient Compliance to prescribed antihypertensive medication regimens: A report to the National Heart, Lung and Blood Institute"

Nutrition in the Life Cycle
P.O. Box 24770
Los Angeles, CA 90024

Provides The Sodium Restricted Diabetic Diet in English and Spanish, Juliet G. Bringas and Teresa Y. Chan

Office of Communications and Public Affairs
Room 14A-55
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Provides a 78-page annotated guide to publications and audio visual aids available in Spanish from more than 100 organizations throughout the nation. The over 400 items described in the guide cover a wide range of health and mental health subjects including diabetes, diet and nutrition, prenatal and infant care, family planning, alcohol and drug abuse, mental and emotional illness, heart disease, foot care and physical fitness.

Planned Parenthood Association, Inc.
Education Department
1200 S.E. Morrison
Portland, OR 97214

Provides a slide/tape program on family planning narrated in Indochinese languages that shows an Indochinese couple visiting a family planning clinic. Family planning methods of birth control and reasons for spacing or limiting births are explained. Basic terms such as birth control, sperm, and ova are defined. The male and female reproductive systems are described and diagrammed.

Refugee Education Resource Center
Griggs Midway Building
Suite 340S
1821 University Avenue
St. Paul, MN

Provides Indochinese Patients: Cultural Aspects of Medical and Psychiatric Care of Indochinese Refugees. A packet of publication materials including articles entitled:

"Health Message to the New Refugees"
"The Hmong (Meo) of Laos"
"Indochinese Cultural Traditions"
"Southeast Asian Social and Cultural Customs: Similarities and Differences"
"Health and Disease: The Indochinese Perspective"
"Southeast Asian Health Beliefs and Practices"
"Modern and Traditional Practices of Vietnam"
"Assessment of Mental Health Status of the Indochinese"
"The Indochinese Mental Health Paraprofessional: What do we want?"
"Mental Health and Illness Similarities and Differences between Vietnamese, Cambodian, H'mong"
"A Quadrilingual Manual and Directory. A Mental Health Guide for Southeast Asians"
"A Mental Health Training Model for Use with Indochinese Refugees"

South Dakota United Indian Association
919 Main Street, Rm. 12
Rapid City, SD 57701
605-348-5300

Produces pamphlets on health education relevant to specific Indian tribes. For example, they have developed three bilingual-bicultural pamphlets for the Sioux Tribe concerning High Blood Pressure control stressing family involvement in health care, reminding Sioux with high blood pressure to have check up, and using the cultural-historical background of the Sioux as a motivating factor in health care. Other tribes for which materials have been prepared are: the Lubee, the Alabama Chousatta of Texas, and the Hopi. They also have developed a sensitivity packet providing information on cultural differences.

Publications:
"Nutritional Wheel for Native Americans"
"Wiconi presents Wiconi Pazo -- the circle of Life"
"Will High Blood Pressure Make the Miccosukee Tribe Exctinct?"
"Help Them to a Good Life"
"Survival (Information on High Blood Pressure)"
"Medicine Man's Viewpoint on Hypertension"
"Hypertension Management in American Indian Communities"
"Sensitivity Packet for Non-Indian Health Practitioners"

U.S. Department of Agriculture
Agricultural Extension Service
University of Minnesota
St. Paul, MN 55108

Provides "Getting to Know the Vietnamese Food Habits and Culture"

U.S. Department of Health and Human Services
Office of Refugee Resettlement
Room 1229, Switzer Building
330 C. Street S.W.
Washington, DC 20201

Publications:

Refugee Resettlement in the United States: An Annotated Bibliography on the Adjustment of Cuban, Soviet and Southeast Asian Refugees, 1981.

Report to the Congress, Refugee Resettlement Program, January, 1981
Includes the following information: Legislative initiatives, key executive branch activities and program developments, refugee appropriations, admissions, population profile, resettlement program, employment, and adjutment of status and citizenship.

Medical Guide & Glossary prepared in four editions: Cambodian, Laotian, Vietnamese and English.

Lao Refugee Orientation Handbook lists information on refugee status, the U.S., living in the U.S., (housing, food, health care, employment, education, shopping, and community resources), with a list of Immigration and Naturalization Offices. In Laotian script.

Vietnamese Refugee Orientation Handbook, provides the above mentioned information only in Vietnamese script.

Living With An American Family, this booklet is entirely written in Laotian.

University of Minnesota
School of Public Health
1360 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, MN 55455

Provides nutritional education materials for Southeast Asians. They include the following brochures and booklets:

"Nutrition Education for Southeast Asians"
WIC Program information brochures translated into Laotian, Cambodian and Vietnamese languages and script including the following--
- "Healthy eating for children"
- "Introducing solids"
- "Are Fat Babies Healthy Babies"
- "Healthy Snacks for Children"
- "Using WIC Foods"
- "Food During Pregnancy"

Visiting Nurse Association of Milwaukee
1540 N. Jefferson St.,
Milwaukee, WI 53202

Provides Comidas Hispana en Dietas Diabetica/Spanish Foods in Diabetic Diets, 1975
$2.00 plus mailing charges.
"This bilingual instruction booklet on diabetic and reducing diets shows Spanish American patients how to include some of their preferred foods with these restrictions. General suggestions for calorie reduction and an explanation of the food exchange groups are presented; followed by 22 recipes. Each recipe includes an exchange breakdown for one serving. A rather unique resource, it should prove very helpful to educators working with this ethnic group." J. of Nutrition Education 8(1):36, Jan.-Mar., 1976.

U.S. Dept. of Health and Human Services
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Services Research
3700 East-West Highway
Hyattsville, MD 20782

Provides Hispanic Health Services Research: A Preliminary Bibliography (DHSS Publication No. (PHS) 81-3300).

Wicone Project
919 Maine Street, Room 12
Rapid City, SD 57701

Publishes bilingual health information pamphlets for American Indians (primarily Sioux).

AGENCY SOURCES FOR LOW LITERACY MATERIALS

Patient Learning Associates, Inc.
4 Chilham Ct.,
Potomac, MD 20854
(301) 340-9894

Michigan Health Council Health Promotion Project
1407 S. Harrison Rd., Suite 340
East Lansing, MI 48823

AGENCIES THAT SERVE THE HEARING- AND SIGHT-IMPAIRED

Listed below are agencies that serve the hearing- and sight-impaired populations. Many of the national agencies have state or regional affiliates. Local affiliates will often respond to queries more quickly and sometimes will have information specific to the unique demographic characteristics for a particular region or state.

Agencies and Materials for the Hearing-Impaired

Alexander Graham Bell Association of the Deaf
3417 Volta Place, N.W.
Washington, DC 20007
Voice & TTY 202/337-5220

Committed to teaching of speech- and lip-reading to persons with impaired hearing.

American Deafness and Rehabilitation Association
814 Thayer Avenue
Silver Spring, MD 20910

Publishes Journal of Rehabilitation of the Deaf and Deafness Annual

American Organization for Education of the Hearing Impaired
1537 35th Street N.W.
Washington, DC 20007

Affiliated with the Alexander Graham Bell Association of Deaf

American Speech-Language-Hearing Association (ASHA)
10801 Rockville Pike
Rockville, MD 20852

Publishes ASHA Journal, Journal of Speech and Hearing Disorders, and Journal of Speech and Hearing Research

Associations for Education of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

Publishes American Annals of the Deaf

Better Hearing Institute
1430 K Street, N.W., Room 200
Washington, DC 20005

Captioned Films for the Deaf Distribution Center
814 Thayer Avenue
Silver Spring, MD 20910

Distributes entertainment films for a hearing-impaired audience.

Council on Education of the Deaf
c/o Gallaudet College
PreCollege Programs
Seventh and Florida Avenue, N.E.
Washington, DC 20002
202/447-3737

Deaf Counseling, Advocacy and Referral Agency
1624 Franklin Street, Suite 1220
Oakland, CA 94618

Deafpride, Inc.
2010 Rhode Island Avenue, N.E.
Washington, DC 20018

Provides Health Services: Making health services accessible to the deaf and hearing impaired patient. This is a 3-page pamphlet that provides information on assisting the medical and health professional to better serve the deaf community.

Gallaudet College
Kendall Green
Washington, DC 20002
Voice: (202)447-0741
TTY: (202)447-0480

Provides "GCAA Alumni Newsletter: Selected bibliography on health care delivery for deaf patients" and "1981 Catalogue of Publications"

Gallaudet College Sign Language Programs
Kendall Green
Washington, DC 20002

Sponsors courses in sign language and total communication including the following publications:

"Information on Deaf Adults"
"Stuck for the Right Word?"
"You and Your Deafness"
"Heredity and Deafness"

The Public Service Program of Gallaudet College provides the following:
"Worker's Compensation: Some Facts for Deaf People"
"Legal Information From the National Center for Law and the Deaf"
"The Deaf Person As a Patient in the Hospital"

"Communicating with Hearing-Impaired Patients"
"What if your Patient is Also Deaf?"
"Deaf-Patient Care: A Special Concern to me"

Mainstream, Inc.
1200 15th St. NW, Suite 503
Washington, DC 20005
202/833-1136 (V-TTY)

Provides A Hospital Guide to Section 504 -- information for health professionals about how to work with individuals who are handicapped (price $37.50).National Association of the Deaf

National Association of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910
Voice: 301/587-1788
TTY: 301/587-1791

Source of materials and names of resource people. Requests in writing preferred.

National Association of the Deaf-Blind of America
616 E. 124th Street
Cleveland, OH 44108

National Association for Hearing and Speech Action
6110 Executive Blvd. Sute 1000
Rockville, MD 20852
301/877-8682

National Center on Educational Media and Materials for the Handicapped
Ohio State University
220 West 12th Avenue
Columbus, OH 43210

National Center for Law and the Deaf (NCLD)
7th Street and Florida Avenue, N.E.
Washington, DC 20002

Publishes NCLD Newsletter

National Registry of Interpreters for the Deaf
P.O. Box 1339
Washington, DC 20013

Both the national office and its local chapters can help hospitals locate certified interpreters and can provide guidelines for use of interpreters in hospitals.

New York League for Hard of Hearing
71 West 23rd Street
New York, NY 10010

Publications:
"Basic Audiology"
"Classroom suggestions for Teachers of Hearing Handicapped Children"
"Help! There's Something Wrong With My Hearing Aid!"
"You and Your Hearing Aid"
"Hints to Help the Hearing Impaired Student"
"Does Your Child Have a Hearing Loss?"
"Which Hearing Aid for Me?"
"Learning to Live With the Hearing Impaired"
"Does Your Baby Hear?"

New York Society for the Deaf
344 East 14th Street
New York, NY 10003

Publishes Chronicle monthly

Planned Parenthood of Seattle/King County
2211 East Madison
Seattle, WA 98112

Provides "Signs for Sexuality: A Resource Manual," developed to assist in teaching human sexuality to the hearing impaired. This manual serves as a dictionary of commonly used signs for sexual vocabulary and includes approximately 160 different terms. Black and white photographs illustrate signs and a simple definition is given for each term. Appendices to the dictionary include illustrations of reproductive anatomy, a cross-reference term list, and selected resources. 1978.

Prince George's County Health Depatment
Hospital Road
Cheverly, MD 20785

Publications:
Your Health Care for Deaf and Hard of Hearing Persons
Feeling Great: A Book of Healthy Mind and Body for Deaf and Hard of Hearing Persons

Self Help for Hard of Hearing People, Inc. (SHHH)
Box 34889
Washington, DC 20034

Special Office for Materials Distribution
Indiana University, Audio Visual Center
Bloomington, IN 47401

Local distribution center for educational captioned films and other teaching aids for Special Education Instructional Media Centers. Free catalogs of materials, free loan and inexpensive purchasing. NOTE: Educational captioned films only require audience to have one person who is hard of hearing.

United Hospitals, Inc.
Department of Health Education
125 W. College Ave.
St. Paul, MN 55102

Offers videotapes for use in training hospital staff members in techniques for communication with deaf patients and illustrated health-related materials for use by deaf persons.

U.S. Department of Health and Human Services
Public Health Service
Health Services Administration
Bureau of Community Health Service
Office for Emergency Medical Services
Rockville, MD 20857

Provides the following booklet: EMS and the Hearing Impaired: Overcoming the Barrier, DHHS Publication No. (HSA) 81-5902. This booklet discusses some of the problems encountered in emergency situations by the hearing impaired and the emergency medical technicians and paramedics. It suggests some possible preventive actions and considerations for both groups to improve the delivery and quality of emergency care of deaf and hearing impaired people.

Winter Park Memorial Hospital
200 N. Lakemont Ave.
Winter Park, FL 32789

Provides information on developing special charts to be used by hospital staff members in communicating with deaf patients about emergency and routine procedures.

Periodicals for Education of the Hearing Impaired

Directory of Programs and Services for the American Annals of the Deaf,
5034 Wisconsin Avenue, N.W., Washington, DC 20016

Yearly publication providing comprehensive state-by-state information on education rehabilitation and evaluation services for hearing-impaired children and adults.

The Endeavor, Publication of the International Association of Parents of the Deaf, 917 Thayer Avenue, Silver Spring, MD 20910.

Informative newsletter containing articles on education, services and suggestions for living with hearing impaired children.

The Deaf American, National Assocition of the Deaf, 814 Thayer Avenue Silver Spring, MD 20910.

Official publication of the NAD. Contains news about the deaf community and articles on deafness.

Agencies & Materials for the Sight-Impaired

American Alliance for Health, Physical Education, Recreation and Dance
1201 16th Street, N.W.
Washington, DC 20036

Publishes Physical Education and Recreation for the Visually Handicapped

American Council for the Blind
501 N. Douglas Avenue
Oklahoma City, OK 73106

American Foundation for the Blind
15 West 16th Street
New York, NY

Publications:
International Guide to Aids and Appliances for Blind and Visually Impaired
Directories of Agencies Serving the Visually Handicapped

American Diabetes Association
2 Park Avenue
New York, NY 10016
(212)683-7444

Iowa Commission for the Blind
Fourth and Keosauqua Way
Des Moines, IA 50309

Publications:
Diabetes for Diabetics: A Practical Guide (Braille), G. F. Schmitt, 4th ed. (Miami: Diabetes Press of America, 1973). Price: $39.00

The Diabetic at Work and Play (Braille). B. R. Boshell. (Springfield, IL: Charles C. Thomas, 1971). Pricd $26.00

Enjoying Food on a Diabetic Diet (Braille) E. M. Meyer (New York: Doubleday, 1971). Price: $26.00

Exchange List for Meal Planning (Braille), (Des Moines: Iowa Commission For the Blind). Price: $6.50

Library of Congress
Division for the Blind and Physically Handicapped
1291 Taylor Street N.W.
Washington, DC 20542

Provides Diabetes as a Way of Life (Braille)
This braille volume discusses the major aspects of diabetes and contains instructions for urine testing, various insulins, and other information. Not for sale through the Library of Congress but can be borrowed.

Mainstream, Inc.
1200 15th St. NW, Suite 503
Washington, DC 20005
(202)833-1136

Provides A Hospital Guide to Section 504 -- information for health professionals about how to work with individualis who are handicapped (price - $37.50.)

National Association for the Visually Handicapped
305 E. 24 Street
New York, NY 10016

National Society for the Prevention of Blindness
79 Madison Avenue
New York, NY 10016

Publications:
"About the National Society for the Prevention of Blindness"
"Catalog Publication/Films 1981-82"

National Diabetes Information Clearinghouse
Westwood Bldg., Room 603
Bethesda, MD 20205
(202) 842-7630 or (301) 496-7433

Provides "Materials and Aids for visually impaired diabetics: selected annotations" NIH Pub. No. 80-1873, July 1980.

The National Eye Institute
National Institutes of Health
Bethesda, MD 20205

Publications:
"Know Your Eyes"
"Macular Degeneration"
"Glaucoma"
"New Treatment for Glaucoma, Sneak Thief of Sight"
"Corneal Diseases"
"Refractive Errors"
"Cataract: Focus on Research"
"NIH Consensus Development Conference Summary -- Intraocular Lens Implantation"
"Soft Contact Lenses"
"Artificial Lenses for the Eye"
"Retinitis Pigmentosa"
"Retinal Detachment"

New York Association for the Blind
111 East 59th Street
New York, NY 10022

Provides An Evaluation of Devices for Insulin-Dependent Visually Handicapped Diabetics. K. Hynes; M. Galligan; L. Saffioti (New York: New York Association for the Blind, n.d.). Price $.35.